WITH WOMEN : A REFLEXIVE PROJECT

Knowledge and Power in Midwifery Education

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Abstract

The recent development of pre-registration midwifery education in England has focused attention on what it means to be a midwife - to be 'with woman' - and the educational requirements for midwives. Where previously the majority of midwives trained first as nurses and then completed a post-registration course now, there is no need to be a nurse in order to become a midwife. These new programmes, at either diploma or degree level, are a minimum of three years in length and are linked with institutions of higher education. In this thesis, I explore the views of students on two of the midwifery diploma programmes. The research was set up as part of a national evaluation project, funded by the Department of Health (Kent et al 1994).

As part of a democratic approach to research and evaluation, I use a form of participatory research called *group inquiry* which comprises a series of workshops that took place over an eighteen month period. Through dialogue with the two student groups we constructed accounts of becoming a midwife. By identifying three central themes of *participation, ways of knowing* and *emancipation* I examine the main features of those accounts. This leads to a discussion of knowledge and power in midwifery education. As a reflexive project, the same three themes are used to examine the connections between knowledge and power in the inquiry process itself. A parallel account of the inquiry process is included in order to highlight the issues raised by doing participatory research. I conclude that the organisation of knowledge and research in modern society is of critical importance in understanding both what it means to be a midwife, with women, and what it meant, being with women in this reflexive project.

Acknowledgements

Many thanks to the student midwives who took part in this research, for their contribution made it possible. I wish them well in their chosen career. I would like to acknowledge the support that I have received from my husband Michael Kent, my supervisors Jackie West and Ruth Levitas, and my friend Tillie Curran. Thanks also to the Economic & Social Research Council, the Department of Health and Maggs Research Associates who funded this research.

I dedicate this thesis to my mother Eve Hessey, who continues to inspire me with her enthusiasm for life.

DECLARATION

I declare that this is my own work and that the views expressed here are mine and not those of the University of Bristol.

JULIE KENT

CONTENTS

CHAPTER 2 - Reflexive Sociology - A Theoretical and Practical Possibility

PART TWO - *THE DIALOGUE*

CHAPTER 4 - GROUP INQUIRY 2 - "Working With Women"

PART THREE - *REACHING AGREEMENT*

CHAPTER 5 - Ideological Dilemmas : Discursive Formations

CHAPTER 6 - Inquiring Together

INTRODUCTION

Becoming a midwife- the pre-registration route

This research began as part of a national evaluation of pre-registration midwifery education in England that was carried out over three years and completed in December 1993 (Kent, MacKeith & Maggs 1994). Pre-registration midwifery education is the preparation as midwives those who are not already registered nurses. These programmes are a minimum of three years in length and may be at either diploma or degree level. Below, I briefly describe the evaluation project and then identify the subject of this thesis.

The development of these programmes followed a commitment by the Department of Health to provide pump priming monies in 1989/90 and 1990/91 for fourteen sites. Since 1916 and more recent EEC Midwives Directives (1980) there has been a distinction between two routes to qualifying as a midwife - either as a direct entrant to midwifery or by training as a nurse first. There has been a longstanding debate about the relative merits of each route. The period of training was extended to three years in 1981 for "direct entrants" to the profession with a shortened course of eighteen months for those already trained as nurses. Yet in England, until the 1990's, there have been few opportunities to enter midwifery directly because by 1988 only one direct entry course remained, in Derby. In recent times the majority of midwives first trained as nurses and then completed a post-registration midwifery course. Support for direct entry courses has been divided but concurrent changes in nurse education and the health service (*Working Paper 10 : Education & Training* DoH 1989) created the context for what have now become widespread changes in midwifery education. Where previously direct entry courses were at certificate level, the new pre-registration programmes are either at diploma or degree level and new links with higher education are an essential feature of them. By the autumn of 1993 when the evaluation report was completed, thirty five pre-registration midwifery programmes had been validated and thirty two were current. These numbers exceeded the Government's expectations though in two Regional Health Authorities no such programme had been initiated. The evaluation was funded to examine the implementation of the pre-registration approach to midwifery education. One of the principal aims of the evaluation was to explore the views of those involved. In this thesis I

consider in more detail the students' views of two diploma programmes. This research was conducted at an important historical moment, a time of considerable change and debate about the future of midwifery education. A debate which depends on definitions of what it means to be a midwife.

By focusing in the thesis, on the students' views of their educational experiences and entering into a dialogue with them, I hope to better understand the political processes that shaped their experiences and how they made sense of them. What did becoming a midwife mean to them? In what ways were they able to influence what happened to them? Becoming a midwife may be seen as both a personal and political process. On the one hand individuals had taken up the offer of a place on these programmes in order to train as a midwife. At the same time becoming a midwife meant entering a public arena where the delivery of midwifery services would be their primary aim. In so doing they would become members of a professional group, expected to participate in professional debates, to represent professional concerns and to further the interests of that group.

Students beginning a programme of midwifery education were likely to have various reasons for wanting to become a midwife and diverse backgrounds. Their personal histories had relevance for understanding their views of the course. So why did they want to become midwives and in what ways might they re-construct their own biographies to include an account of themselves as midwives? While the formally stated aims of the programme related to the statutory requirements for midwifery education (English National Board for Nursing, Midwifery and Health Visiting, 1990; 1993) how did these students make sense of their educational experiences and manage sometimes competing and conflicting accounts of what being a midwife could mean? I wanted to compare and contrast accounts of midwifery by examining both official and legal documents, midwifery literature or professional discourse and the students' own accounts. In so far as the educational programme was a form of occupational socialisation the students were expected to assume the professional identity of a midwife, as a pre-requisite to meeting the midwives' statutory obligations and responsibilities, referred to in chapter one. However this was not to be seen as a straightforward process of assimilation with the students as passive recipients of a menu of teaching. Rather, I saw them as actively involved in a process of sense-making through a dialogue between themselves, their teachers and others. This model of "the reflective practitioner" is a well-

recognised one in professional education (Schon 1983,1987) and in recent years of increasing importance in both midwifery and nurse education (Benner 1984). It is a dialogical model of learning and emphasises participation through learning by doing. While the educational theory is not of specific interest here, I note its relevance for understanding the educational process as discourse and the construction of a professional identity as a discursive accomplishment, for practical purposes.

This research looks at the accounts of midwives, officials and others about midwifery practice and education. For, as we shall see, ideas about what counts as acceptable midwifery practice or appropriate education rest on normative assumptions about the role of the midwife. My aim was to explore these ideas and the ideologies central to those accounts. In so doing I wanted to examine how far there was already a consensus about what being a midwife could mean and the extent to which the development of pre-registration midwifery education could be seen as indicative of one. With reference to the discursive practices of the students, officials and professionals, the ways in which power relations constructed those accounts would be explicated. This would raise questions about the status of different accounts and how certain versions might take priority over others. For example, as students on these programmes how did they construct their identities as midwives, and in what ways were they able to contribute to the future development of either education policy or midwifery practice? How, as part of a democratic and responsive approach to evaluation and research, could their views be heard?

Group Inquiry

By adopting a collaborative and participatory research method which I refer to here as *group inquiry* I hoped that the students' voices would be heard. The thesis therefore examines, in detail the methodological issues raised by the inquiry and in chapter two introduces three important themes - *participation, ways of knowing* and *emancipation.* These themes are seen as central to an understanding of group inquiry, and as characteristic of participatory action research as a democratic procedure. Through a discussion of these themes I explore the ways in which power structures the research process and the "politics of truth" (Barrett 1991). The relationship between democracy and truth will be seen as a critical one for, through group inquiry, I place particular importance on the ways in which the students were able to participate in the research, the claims to knowledge

that could be legitimated through this process, and the extent to which that knowledge was emancipatory. While not suggesting that group inquiry provides any kind of ontological guarantee, I shall argue that a democratic approach to research provides the best possible outcome by producing some kind of agreement about the claim to knowledge being made. This outcome is 'best' in the sense of being morally justifiable, for it recognises the way in which subject positions are co-constructed and how, through dialogue, the values, needs and interests of each participant may be articulated. This Habermasian view does not suppose that an 'ideal speech situation' pre-exists, but rather examines reflexively the conditions under which the inquiry took place and in chapter six, with reference to the work of Benhabib's revised discourse model of legitimacy (Benhabib 1992, 1994), I argue that acceptable knowledge and the basis for political action could be agreed.

Group inquiry is seen here as a dialogue between the student midwives and me, where we sought an agreement about what it means to be a midwife and more specifically what the key issues were for students on these two pre-registration education programmes. So chapter one introduces the voices of midwives through analysis of offical and legal documents, and the midwifery literature. This provides a context for understanding what the students had to say. Chapter two introduces a sociological voice by setting out what were important methodological issues and describing how group inquiry was set up as part of the evaluation project. Chapters three and four present a summary and first level analysis of the dialogue that took place during regular meetings held over eighteen months. Each chapter is written in two parallel sections, one giving an account of becoming a midwife and the other telling a story of the inquiry process. In conclusion, the primary concerns and issues are highlighted.

Chapter five then explores in more depth the three central themes of participation, ways of knowing and emancipation. Through the inquiry process it becomes apparent that these themes provide a valuable framework for thinking about the accounts of becoming a midwife. Those accounts uncovered three related areas: a) midwifery concerns about the conditions for participating in professional practice; b) the claims of midwives to have practical knowledge and skills that are distinct from what doctors or nurses do; and c) a belief that by working with women, midwives might assist in the emancipation of women through childbirth.

There is a symmetry to the thesis, for by working with the students in group inquiry and analysis of the difficulties and issues encountered there, I recognise that a) the conditions for participation in the inquiry, b) the knowledge claims I might wish to make and c) the extent to which through working with them I could assist in the emancipation of women; matched their concerns about becoming a midwife. It is in this sense that this research is a *reflexive project* and in chapter six I acknowledge how the conditions for knowledge production, for producing my own account of the research, are contingent. My analysis of subject-object relations and a brief assessment of the debates between modernists and postmodernists enables me to conclude that a revised discourse model of democracy is useful both for understanding the process of inquiring together and what it might mean to be a midwife, to be *with women.*

With a better understanding of contemporary debates in feminist theory that challenge a unitary concept of 'woman' I shall show how a politics of midwifery informed by a fixed notion of 'midwife' leads to arguments for a separate educational programme which emphasises the differences between midwives and nurses, midwives and doctors - a form of *identity politics.* In contrast, by adopting this discourse model, the ways in which subject-object relations are mediated by language becomes visible. Group inquiry method made this possible precisely because it sought to break down the fixedness of categories such as researcher and researched, subject and object, theory and practice, process and content. In this way, by building on criticisms of 'scientific' method and challenging foundationalist claims to truth, I adopt a position that recognises a plurality of interests, that celebrates diversity but is consistent with the project of modernity and continues to support a democratic ideal where political action is based on rational agreement. This does not mean that I lapse into a masculinist, liberal view where unencumbered selves take part in public debate, but rather that I support a politics of presence where differences are not relegated to the private sphere but ways are found to include them in public arenas (Phillips 1994). In the context of midwifery education this means finding ways in which diverse interests may be articulated, giving voice to competing and conflicting views and maximising the opportunities for public debate in order that agreement may be reached. My hope is that this research has been instrumental in this regard and that in addition to my work on the evaluation project the scope of that debate has been widened.

PART ONE - *VOICES*

CHAPTER 1

Midwifery Voices - The Development of Pre-Registration Midwifery Education.

Introduction

This chapter provides a discursive context for understanding the students' accounts of becoming a midwife. Through a detailed analysis of a number of legal and policy documents and reference to midwifery literature I will examine three key areas -1). the organisation of maternity services; 2) legislation in midwifery; and 3) changes in midwifery education. I will set out contemporary debates about the place of midwifery in recent health service provision and the way in which the medical management of childbirth has been criticised. These criticisms are related to arguments for reorganising midwifery services, to enhance 'continuity of care' and make more effective use of midwives' skills and knowledge. Particular attention will be focused on the conclusions of a House of Commons Health Committee which took evidence at the time of this research and reported on the maternity services in 1992[1]. I suggest that the voices of midwives had been heard by the committee and while others, notably consumer groups, may have expressed similar views, its findings make normative assumptions about the role of the midwife and adopt what I refer to here as a midwifery model of childbirth which emphasises pregnancy as a normal process.

In the second section of the chapter I will discuss the legislative framework for midwifery practice and education. This is important, for however midwifery services are organised, and whatever the programme of education, there are legally specified responsibilities for midwives. Moreover there are statutory bodies which regulate and control the profession. Analysis of the function of these bodies and their constitution illustrates how midwives have been engaged in a continuing struggle to free themselves from the control of both the

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1 Subsequent developments in policy are outlined in appendix 1 since they occurred after the student workshops were completed

medical and nursing professions. There are institutional mechanisms, legally defined, for regulating and controlling professional boundaries (see also Donnison 1977; Witz 1992; Towler & Bramall 1986; Katz Rothman 1982) and it is in this context that recent events have led to some midwives supporting the idea of a new Midwives Act which would set them apart from nurses and, in their view, give midwives greater autonomy. I conclude that in many ways the law is permissive and allows for a sphere of responsibility and practice to be defined, but gives midwives few rights; there is little evidence to suggest that changes in the law would enhance their status or power.

Changes which have been taking place in midwifery education and the development of pre-registration midwifery programmes have been seen as a way to increase the status of midwives and to strengthen their professional identity. The final section of this chapter therefore describes how concurrent changes in nurse and midwife education have added impetus to arguments that they are two distinct professions. Consultation around the UKCC[2] document Project 2000 in the 1980's focused debate about whether midwives needed to train first as nurses or whether a 'direct entry' or pre-registration route was preferable. While opinion within the midwifery profession was divided, vociferous groups (eg.the Association of Radical Midwives) and individuals in powerful positions were instrumental in shaping early developments. This section therefore concludes with a discussion of the commitment by Government and the statutory bodies to promote the pre-registration approach. Against this background, the evaluation project and this study were set up. The central themes - of professional power; claims to knowledge and skills that are distinct; and the belief that midwives are best placed to meet the needs and interests of women; - run through the discussion in this chapter and will be elaborated by the students' own accounts in group inquiry in chapters three and four.

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[2] United Kingdom Central Council for Nursing, Midwifery & Health Visiting (see appendix 5)

1.0 A Report on the Maternity Services

In February 1992 the House of Commons Health Committee produced a second report on its inquiry into Maternity Services which convened in January 1991.

> *"The Committee was stimulated into conducting this inquiry by its awareness of the fact that it is now over a decade since the last major inquiry into these matters by the then Social Services Committee and* ***by hearing many voices*** *saying all is not well with the maternity services and that women have needs which are not being met".* (HoC 1992:para 2; emphasis added)

Among those voices are the voices of midwives who have spoken out in favour of reform. Their voices may also be heard in the texts of others who presented evidence to the committee or have commented on the report. While it can not be assumed that midwives speak with one voice I shall focus on the evidence presented to this Committee and draw out the central themes identified above for these are predominant in the midwifery literature.

The report details a range of views expressed about the current organisation and provision of maternity services in England. Evidence was taken from consumer groups, individual women with first hand experience of maternity services, representatives from professional organisations, independent midwives[3], health authority members, individual midwife teachers, General Practitioners, obstetricians, epidemiologists and midwifery researchers and a range of pressure groups. However in its findings the committee adopts a midwifery model of childbirth or "non-medical" view, which is contrasted with a medical model. Indeed the medical management of childbirth as an organising principle for the delivery of maternity services is strongly criticised. In this section I analyse the report in detail in order to explore these competing ideologies.

The introduction sets out the remit of the Committee and states that mortality

> *"cannot be the only determinant of satisfactory maternity services. We set out on this inquiry with the belief that it is*

[3] An independent midwife is a midwife who works outside the NHS on a private, contractual basis with individual women clients.

possible for the outcome of a pregnancy to be a healthy mother with a healthy, normal baby and yet for there to have been other things unsatisfactory in the delivery of the maternity care." [4] (HoC 1992:para 3; emphasis added)

In an effort to discover whether women receive a "life-enhancing" start to family life the report takes the view that

"becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health" [therefore]*"normal birth of healthy babies to healthy women* [is only] *the starting point and focus"* [of the inquiry]. (HoC 1992:para 4; emphasis added).

The representation of pregnancy as a "normal process" is a view espoused most strongly by midwives as will become evident in this analysis. Adopted by this Committee it is contrasted with the views that prevailed a decade earlier and indicates a shift in thinking about acceptable indicators of performance and at the same time raises questions about the utility of earlier measures as we shall see.

Referring to the development of a maternity service which has become increasingly hospital-centred, the Committee now

"believe that the debate about place of birth, and the triumph of the hospital-centred management, have led to the imposition of a whole philosophy of maternity care which has tended to regard all pregnancies as potential disasters, and to impose a medical model for their management which has had adverse consequences on the whole way in which we think about maternity care " (HoC 1992:para 32; emphasis added).

Consequently the Committee conclude that

"it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions" (HoC 1992:para 33).

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[4] There is a continuing controversy about the use of mortality statistics as a measure of pregnancy outcome or indicator of the best place to have a baby, home or hospital. This is referred to in the report and elsewhere - see for example Tew (1990). The work of the National Perinatal Mortality Unit has made a significant contribution in this area (Effective Care in Pregnancy (1989) For a discussion of the use of mortality statistics as performance indicators or measures of outcome in health services see Klein (1983), Mays & Bevan (1987).

While believing that the case for birth in hospitals cannot be justified on grounds of safety, in the absence of conclusive proof that it is safer, the Committee believes that the use of alternative criteria for judging the outcome of maternity services does not necessarily favour a particular professional group but should enhance the control of mothers and mothers-to-be. Nevertheless it would seem that the burden of proof rests with those who would advocate a medical model of care.

Introducing the evidence from the professionals the Committee note that

> *"Much of what we heard appeared to be concerned with which group should have control over the maternity services and we analyse these apparent rivalries elsewhere in this report."* (HoC 1992: para 175)

There is apparently little consensus among professionals, about what women need in the way of maternity care. Furthermore

> *"differences of opinion in this area appear to stem from divergent philosophies of the management of pregnancy and childbirth between what has been frequently described to us as a 'medical' and 'non-medical' view of the process"* (HoC 1992: para 175; emphasis added).

The report therefore sets out an important opposition between a medical and non-medical view which is seen as not only signifying two contrasting approaches to pregnancy and childbirth but underlies the current form of midwifery services in this country.

With reference to this divergence of opinion the present form of the organisation of maternity care is seen as reflecting the view of pregnancy as a potentially hazardous event which is best managed by a system of "shared care" that encourages hospital delivery under a consultant. As outlined here and elsewhere (Oakley, 1984; Campbell & Macfarlane, 1987,1990) health policy has promoted the idea that the safest place for women to give birth is hospital; in order to prevent maternal and perinatal mortality, prudent women should seek hospital and medical care during pregnancy and childbirth. The reasons for this state of affairs merit further explanation and will be discussed below. What is of significance here is that the dominance of a medical view is clearly questioned in the report (see also Kingman 1990) and the idea that hospital care is best (as opposed to a care at home) is challenged on several grounds.

First, as already indicated, the statistical relationship between declining mortality and hospitalisation is called into question, and adverse effects of medical intervention set against any claim to increase safety.[5] Secondly, the care of women is seen to have become severely fragmented as they have contact with various professionals (sometimes in large numbers). Thirdly, there is duplication of effort between midwives, GP's and obstetricians which is seen as both wasteful and unsatisfactory to all concerned. Fourthly, it is argued that in practice, women are seldom able to choose the kind of maternity care they might wish for themselves because there has been an erosion of the range of options available to them. I shall now examine these arguments in depth.

1.1 Medical management of childbirth

The justification for medical intervention in pregnancy and childbirth has most usually been argued in terms of a safe delivery and healthy baby. Measures of safety and health have traditionally been in the form of mortality statistics yet when these are ruled out of court as insufficient or unproven (see above and work of NPEU[6]), the consequences of a medical model of care are contentious.

The "medicalisation of childbirth" has been discussed by many writers (eg. Donnison, 1977; Oakley, 1980, 1984; Katz Rothman, 1982; Kitzinger, 1988) and is seen as synonymous with the dominance of men and the growth of science in the western world, a feature of a capitalist, patriarchal society. With the development of new techniques the possibilities for greater control over women's bodies have been realised (Oakley, 1989:217). Evidence of iatrogenesis (Illich, 1976) may be cited. In obstetrics, techniques such as the use of drug therapy to induce labour, relieve pain during childbirth, and "actively manage" the birthing process, have had a significant effect on the experiences of women, often reducing their control and active participation (Beinhart, 1990).

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[5] A rather neat point is made that the argument that women should not be encouraged to give birth at home is undermined by the observation that we do not close minor, rural roads because there is a risk of accidents!

[6] see note 3 above.

Surgical procedures of episiotomy, Caesarean section and instrumented delivery (eg. using forceps) increased dramatically from the 1960's and extended the obstetricians sphere of reponsibility (Schwarz 1990) Discontent and resistance to this progressive "dehumanising" of pregnancy and childbirth has been increasingly expressed since the 1970's[7]

This perspective has even been taken on board by the President of the Royal College of Obstetricians and Gynaecologists (RCOG) who was reported as saying, in his evidence to the select Committee

> *"We have become, if anything, slightly too mechanistic in our approach to obstetrics ...too much science, too little caring; too little compassion, too much intervention. I accept that and I think it is something we, as a profession, need to address and we are being called to address it"* (HoC 1992:para 183).

While the Committee members challenged the term "slightly", they considered these remarks to concede, at the very least, a need to re-examine current working practice in obstetrics, in response to the requests of women using maternity services. However, whether this marks the beginning of a significant change remains to be seen and seems less likely in the light of the RCOG's subsequent response to the report (published March 1992). For while *"the need to enhance the emotional and social components of care during pregnancy and childbirth"* is accepted by the RCOG, it expresses concern that the recommendations of the Committee *"might be interpreted as negative in relation to the technical and scientific advances in obstetrics"* (RCOG, 1992:2). The Committee's report had noted the criticisms made of changing *"fashions"* in obstetric treatments, such as induction, and episiotomy, and expressed concern that medical (and midwifery) professions had not audited maternity care adequately (HoC 1992: paras 235 -236).

However, according to the RCOG *"there can be no retreat from science"* since for many women it provides the *"only means"* for them to have a safe delivery and healthy child. Furthermore, women themselves are seen as seeking *"a high level of control over many aspects of their*

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[7] For accounts of the growth of "Pressure groups and Maternity Care" see Durward & Evans, 1990; Kitzinger, 1990; Garcia et al, 1990.

reproductive lives and this can only be exercised with the help of technology". In addition, the continued use of technology depends on further investment and research, since, *"progress is more likely to be made through further investment to advance technology rather than rejecting it"* (RCOG, 1992:9).

There is little here then to suggest that any ground is being conceded to an alternative approach to maternity care (including home confinements, aromatherapy, water births). Indeed the RCOG advises that all alternative approaches be researched and subjected to scrutiny before being introduced, and resource implications considered; and, in order to meet the demands of consumers for improved services, it seeks additional numbers of consultant obstetrians, since access to obstetric care should, in its view, remain the right of all women and therefore be readily available. As might be expected the RCOG seem anxious to ensure that maternity care remains centralised, in the hospital because

> *"the hospital antenatal clinic is the route to screening (for abnormalities) and it enables a programme to be delivered in an effective way"* [and] *"it is easier to provide co-ordinated care in a hospital environment"*. (RCOG,1992:4,5).

So rather than seeing the present arrangements as resulting from either a misuse of medical technology in maternity care, or structural weaknesses in the organisation of services, the RCOG suggests that additional resources will both strengthen the use of technology, in the interests of women, and tighten management or co-ordination of service. The debate is shifted from a challenge to a medical model of care to a request for additional resources. [8]

This is in stark contrast to the evidence given by two organisations which expressed views of consumers and midwives. According to the Association of Improvements in the Maternity Services (AIMS)[9], increased monopoly of the maternity services by obstetricians was not only based on the mistaken belief that perinatal mortality was reduced as a direct result, but also meant that

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[8] The Committee themselves conclude that rather than an increase in resources a redistribution of existing resources is required (HoC 1992:paras 343, 451).

[9] See Durward & Evans, 1990:260 for an outline of its founding in 1960 and Oakley, 1984:236

> *"many health authorities and obstetricians have pursued a profligate policy involving largely inappropriate interventions, closures of small potentially cost-effective maternity units, and the routine use of unevaluated expensive technology and procedures"* (AIMS, 1991a).

Such a policy is identified as being both wasteful and contrary to the wishes of parents and user groups. AIMS (1991a) calls for a reduction in obstetric posts, a review of the General Practitioner's role in maternity care and *"a proper recognition of the central role and status of the midwife in the provision of maternity care"* . AIMS is particularly critical of doctors' (and midwives') training, which is hospital based and acutely interventionist and thereby is seen to promote a view of pregnancy and childbirth as abnormal. Junior doctors are thought to have little opportunity to learn about "normal" birth processes and they note that

> *" the need to provide a supply of pregnant women for training and research has been a powerful but unstated influence on centralisation of maternity care. The result has been increased expense, increased iatrogenesis and decreased consumer satisfaction. The time has come for students, doctors and midwives to be taught in settings which meet the needs of mothers"* (AIMS, 1991b).

In proposing a radical alternative AIMS suggests that junior doctors and medical students be trained by community midwives.

The Association of Radical Midwives (ARM) also gave evidence to the Committee and stated *"That the philosophy underlying the treatment of women during childbirth in the UK is not appropriate in most cases"*. Obstetric philosophy is referred to here as treating birth as

> *"a potential disaster fraught with hazards"* [so that] *"Instead of antenatal care being designed to promote* [women's] *well-being, it is designed to detect abnormalities. Instead of birth being conducted in a supportive atmosphere, respectful of the human body's ability to labour and deliver a healthy baby, it is an 'intensive care' situation in which the body is starved, monitored, accelerated and delivered with the prevailing philosophy of 'just in case disaster happens'"* (ARM, 1991:para 1.2).

In the light of these comments the ARM argue that the midwife's role is underused and that by placing midwives at the centre of maternity care, enabling them to define what is "abnormal" or "normal" will greatly reduce the overuse, wastage and expense of high tech treatments that are inappropriate for most women's needs. Since

> *"compared with the 5-15 normal deliveries a student doctor carries out during his 6 week stint in the maternity unit the midwife's experience leads to a greater expertise in normal antenatal care, normal labour and delivery and the normal postnatal period. As between 80-90% of women have "normal" pregnancies, labours and postnatal periods, it is obvious that the midwife who is -cost effective, well trained and efficient should be planning and implementing care for childbearing women. Whereas in the United Kingdom the policy and practice in most maternity units is controlled by medical staff - the experts in abnormalities in childbirth, well trained, but expensive, and not always being used appropriately."* (1991 para 2.2).

We see here how a division of labour between midwife and obstetrician rests on definitions of 'normal' and 'abnormal'. However, while the ARM seek to alter the organisation of services so that midwives' skills are more effectively used, these definitions remain essentially in tact. It points to the view generally expounded by obstetricians:*"the application of the philosophy that childbirth is only normal in retrospect"* and threatens the execution of the midwives' *"responsibility for the care of normal childbirth"* (ARM 1991:para 3). The argument for change is substantiated by proposing that midwives, as experts in 'normal' processes, are more cost-effective in providing a maternity service. Definitions of 'normal' and 'abnormal' are not themselves examined here but the division of labour as an economic relationship is contested. Moreover, defining the abnormal is primarily seen as the midwives' task. This promotes the idea of a referral system at the discretion of the midwife and could greatly increase their powers. This view is central to other proposals for increased continuity of care and draws on a legal definition of the midwives' role discussed below.

1.2 Proposals for reorganisation of maternity services to increase continuity of care.

The present system of maternity care consists of "shared care" between midwives, GP's and obstetricians. Most pregnant women are "booked" under the care of a consultant obstetrician or GP and a midwife [10]. Her antenatal care will be shared between the professionals and she may (in theory) receive care from all of them (there may of course be other professionals involved, for example, physiotherapist, social worker). In practice the pattern of her care may vary depending on several factors: the number of visits she is required to attend the hospital antenatal clinic (where she may see the consultant obstetrician but more likely will be seen by various, junior doctors); the extent to which the GP is willing, or able,[11] to offer antenatal or intrapartum care (ie. during delivery); and the availability of community and hospital midwives. There has been much criticism of the system as being fragmented, impersonal and inefficient. (For a discussion of a "Consumers' revolt" see Oakley 1984:chap 10). This view was shared by the Committee who themselves concluded that

> *"the present system of shared care between hospitals and the community should, by and large be abandoned. Hospitals are not the appropriate place to care for healthy women"* (HoC 1992: para 208).

These conclusions are sympathetic to the recommendations of the Royal College of Midwives (RCM) which proposed

> *"the setting up of a community-based primary maternity service. Women should be able to refer themselves directly to midwives, who might be best organised in teams covering specific areas. Midwives should have their own case loads rather than obtaining their clients through the medical structure. Local Midwifery Clinics would be a convenient source of care and advice. Direct referral by midwives to specialists where*

[10] Under the present law, a woman may book with a midwife and no medical practitioner need to involved except should a referral become necessary. However this happens only in a minority of cases.

[11] GP's are paid a fee for maternity services - antenatal, intranatal and postnatal. A minority are on an approved Obstetric list for intranatal care and may assist the woman in a home confinement or a GP bed in a maternity unit where she may go with the community midwife and her GP for delivery and a shortened hospital stay. This is known as a Domino delivery.

problems occurred would ensure the prompt provision of secondary care" (HoC 1992: para206, 218).

A referral system operated by midwives was also supported by the Committee (HoC 1992:para 219). In effect continuity of care during the antenatal period would be promoted by a woman holding her own notes and a reduction in the medical involvement in care, an initiative welcomed by midwives (Flook 1992).

With respect to care during the intrapartum period the Committee was more circumspect, and while advocating increased choice for women in the place of birth, and the care they receive, the way forward was seen as a matter for further negotiation. There was a call for the professions and the NHS to resolve the dispute about the management of labour and place of birth as a matter of urgency (HoC 1992:para 232).Despite this ambivalence, the recommendation that increased choice is made available presupposes that hospital is not necessarily the best place or only acceptable form of care, and that other ways of organising maternity services have merit.

There are two recommendations which are central to promoting continuity of care which have a direct consequence for midwives (and women) - the development of community based antenatal care and 'team midwifery'. The extent to which these might be considered beneficial, and how they might be implemented in practice, depends on how continuity of care is defined. This is itself a topic of current research and debate and has been since the Peel Report in 1970 (cited in Murphy Black, 1992; see also IMS study on Mapping Team Midwifery 1993). Murphy Black explained that one definition of continuity of care may be seen as professionals with a shared philosophy of care; a second definition focuses on the idea of continuity of carer. Often these quite distinct ways of understanding "continuity of care" are collapsed into one. Yet while the first refers to philosophies of pregnancy and childbirth, the second points to the division of labour in caring for women. Although continuity of care may be promoted in other ways, "team midwifery" is frequently seen as an important concept. Team midwifery may refer to a mixed team of professionals, as the RCOG suggest (Daid, 1992; DoH, 1992: para1.6) and could be more readily associated with the first notion of "continuity of care". More often "team

midwifery" is taken to refer to a team of midwives which may be seen as providing continuity of carer.

As set out in the 1992 Committee Report, maternity care is fragmented (in part) because there are a large number of carers involved. There is commonly a disconnection between hospital and community care with separate carers in each setting. At the same time a notion that pregnancy and childbirth is usefully separated into stages dominates. The organisation of midwives into teams (with caseloads[12]) is seen by the Committee as representing

> " *...the most promising way forward towards developing a pattern where women can approach, if not achieve, the ideal of one-to-one care and continuity between antenatal, intrapartum and postnatal care*" (HoC 1992:para 339)

While the shape of "team midwifery" in existing schemes varies (see also IMS 1993) the **potential** for enhancing continuity of care is regarded favourably by the Committee (ie. subject to evaluation and research- see Morris-Thompson, 1992 for an evaluation of a team midwifery scheme)[13].In addition, the development of "midwife-managed units" was recommended by the Committee as a means of providing midwifery care, in a hospital setting, with ready access to specialist obstetric units for those women who require transfer as "abnormalities" arise.

However it cannot be assumed that, of itself, the re-organisation of midwives into teams, necessarily indicates a challenge to a medical model of care. Clearly there may be continuity of carer but that carer may operate within a medical or midwifery model/philosophy of care. Generally, midwives assume that team midwifery and continuity of care are synonymous and that both promote a midwifery model of care. Although "team midwifery" may challenge a medical model of care this does not automatically follow and it is doubtful that on its own it could

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[12] It could be that each individual midwife within a team has a caseload, or the midwife team as a whole might have a caseload. Only the first of these is likely to provide one-to-one care.

[13] AIMS claim , in their submission to the Health Committee, that "there is now sufficient evidence to show that care from teams of midwives reduces mortality, reduces the amount of unnecessary interventions and morbidity, increases satisfaction amongst mothers and is cheaper than the present consultant centred care that the majority of women have" (para 3.3)

be sufficient. This is evident where hospital "midwifery teams" continue to be consultant led.

Nevertheless, the proposals of the Committee can be seen as signifying a re-appraisal of how midwives' skills are used and a retreat from a medical/mechanistic approach to care where childbirth is viewed as comprising distinct stages involving a different professional in each, to a situation where midwives have responsibility for the whole process. Following from this, the expectation is that a woman would come to know her midwife prior to labour and could be supported throughout by either the same midwife or a small team of them. (The idea of a "named midwife" is put forward in the Patients Charter DoH 1991). The adoption of these proposals by the Committee reflects the voices of (some) midwives themselves as indicated in the evidence given by the RCM who apparently *"placed great stress on their conviction that midwives were best placed to provide"* continuity of care (HoC 1992:para 176)[14]. Their position was mirrored by the conclusions reached by the Committee with respect to women who use maternity services *"the majority of them regard midwives as the group best placed and equipped"* (emphasis added) to provide continuity of care and carer (HoC 1992:para 49).

1.3 Interim conclusion

The Government's response to the report in July 1992 was restrained. It reserved judgement on many of the views of the Committee but they set up a

> *"Departmental Task Force, to be led by the NHS Management Executive, to examine and disseminate good practice in selected aspects of the management of maternity services"*. (DoH, 1992:para1.2)

A particular focus of the Task Force, was to produce guidelines on good practice in:

> *" maintaining continuity of professional care and carers thoughout pregnancy, at birth and in the period immediately after birth"*. (DoH, 1992:para1.6)

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[14] The extent to which the RCM reflect the views of practising midwives was recently questioned by the RCOG according to Daid 1992.

While recognising and valuing the midwives' skills (as they claim always to have done) there is no indication that midwives will necessarily be at the centre of maternity services in future. Indeed the Government rejected outright, the Committee's recommendation that "shared care" be abandoned and emphasised instead, the value of interprofessional care (DoH 1992 para 2.6.4). In addition an "expert committee" was set up *"to review policy on care during childbirth"* with the intention of reviewing current policy. [15] This committee was to report in Summer 1993 (DoH 1993 - see appendix 1). The Government would say little about the conflicting "philosophies of care" identified in the House of Commons report. Further research in other areas was expected to inform future decisions on midwife-managed units, the use of birthing pools, and homebirths. In the meantime the Government, in stating two principles at the centre of its view - the importance of safety and choice, indicated no dramatic shift in thinking or practice. This might be seen as considerably less than was hoped for by the Committee and many of those, particularly midwives, who gave evidence to it.

While the Committee's, proposals, if implemented, could have a significant impact on the deployment of midwives, the implications for women are less clear. Although much of the emphasis of the Committee's report was to promote choice and control by women, in the wider context of a developing market system in the NHS it is difficult to see how the purchaser - provider relationship could impinge on any initiatives to promote continuity of care (DOH, 1989, Rider, 1991, Gowdridge, 1991[16]). This aspect, although discussed in the context of GP budget holders, and some Regional services, remained largely unexplored in its report, even though in these cases application of market principles was considered problematic. The Government framed much of its own response in terms of purchasers and providers needing to recognise their responsibilities to women who use maternity services and by promoting its Patients' Charter (DoH 1992:34) although the

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[15] Set out in Maternity Care in Action Part II - Care During Childbirth in 1984

[16] Christine Gowdridge from Maternity Alliance (a consumer organisation) in 1991 hoped that where years of rational argument for saying that community midwifery is efficient and preferable had failed to stem the closure of small maternity units, perhaps the internal market succeed. She was however uncertain about how consumers would be involved in negotiating contracts for maternity services and identified a need for a more direct and open relationship between purchasers and consumers.

precise means of achieving this were unclear. Of particular relevance to this discussion is the ways in which the role of the midwife was understood by the Committee, the Government and others who gave evidence. Competing accounts of the difficulties in providing maternity services rest on competing ideologies of care and on the role of midwives in providing care. This in turn relates to the legislative framework of midwifery practice and education. I shall examine this in the next section to see how the legal definition of the role of the midwife is mobilised by midwives as a means of claiming occupational territory as part of a continuing struggle to enhance their autonomy and status.

2.0 A Legal framework

Many midwives have welcomed the proposals for change in maternity services and the Committee's recommendations are seen by some as

> *"the greatest political weapon they have ever had in support of their claims to become the central providers in maternity services"* (Morris-Thompson 1992).

They are exhorted, in the light of the report to

> *"acknowledge their current inability to fulfill their true role as autonomous practitioners..."* [and must] *"..regain their trust in the normal birth process"* (Kargar & Warren 1992,emphasis added).

The midwife's 'true role' has been the topic of longstanding concern which most usually rests on the legally defined role of the midwife . The midwife operates within a legal framework which is often called upon to support arguments for change and a redrawing of boundaries between professional groups. As a justificatory strategy the law provides a powerful device for strengthening midwifery discourse although the regulatory function of the law has more often (arguably) left midwives in a weaker position. Devries 1982 (cited in Houd & Oakley 1990:165) suggests there is a dual purpose to licensing midwifery practice. It is both enabling, in so far as it recognises the value of what midwives do, and disabling in limiting the scope of their action. This view is reiterated by Oakley & Houd who also assert that the midwives'

> *"professional relationship with doctors began to be defined and codified to the midwives' increasing disadvantage"* [with] *"the emergence of professionalised medicine"* (1990:24).

This section examines the specific ways in which that relationship has been defined and regulated over the past twenty years (for more detailed accounts of earlier legislative change see Donnison, 1977; Towler & Bramhall, 1986).

2.1 The Statutory Bodies

The 1979 Nurses, Midwives and Health Visitors Act set up a new structure to regulate and control these professions (summarised briefly in an editorial of Midwives Chronicle 1987). Following the recommendations of the 1972 Briggs Report, it sought to bring the control of the professions in all parts of the United Kingdom under one body. Its intention was

> *"to make new provision with respect to the education, training, regulation and discipline of nurses, midwives and health visitors and the maintenance of a single professional register"* (DoH 1979:chapter 6).

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and four national boards were established. This Act dissolved the Central Midwives Board (CMB). Such a move was contentious and was perceived by many to signal a loss of midwives' control over their own profession (Cardale, 1990; Cronk, 1990; Frame & North, 1990) although it has also been argued that the CMB had itself been ineffective in empowering midwives since it was dominated by doctors (see for example Cardale, 1990; Robinson, 1990; RCM date unknown). The proposals for a new structure met with opposition and protest, and the ARM launched a campaign to resist them (Thomas 1979). It was suggested that there had been a lack of consultation with midwives and

> *"that those people in the highest echelons of midwifery and nursing held biased opinions concerning the proposed structure and its effects (at field level) because they were thinking and speaking from the standpoint of the bureaucrat"* (Thomas 1979:8).

A Midwifery Committee was set up within the Council. Its role was defined as follows

> *"the Council shall consult the Committee on all matters relating to midwifery and the Committee shall, on behalf of the Council, discharge such of the Council's functions as are assigned to them either by the Council or by the Secretary of State"* (DoH 1979:para 4.2) [furthermore] *"the Secretary of State shall not approve rules relating to midwifery practice unless satisfied that they are framed in accordance with recommendations of the Council's Midwifery Committee"* (DoH 1979:para 4.4).

Interpretation of this and the powers invested in the Midwifery Committee (and the Midwifery Committees of the National Boards) have been a continuing area of debate, and its very existence seen as something of a compromise (Ackerman & Winkler, 1979; Cardale, 1990; Cronk, 1990).

Despite efforts to work within the new structure there was increasing dissatisfaction as changes were implemented which were not approved by midwife members of the midwifery committees. This was highlighted by a change in management structure at the English National Board (ENB) in 1988 which meant that midwifery education officers who were previously accountable to a midwifery professional officer, became managed by the principal professional officer who need not be a midwife[17]. In addition the following year all education officers became "generic" which meant that non-midwife education officers would be able to make approval visits to centres of midwifery education[18]. Midwife education officers could act only as specialist "advisors" (Cronk, 1990; Midwives Legislation Group, 1990a, 1991). The same year a Midwives Legislation Group was set up by the ARM to draw up alternative legislation and a new Midwives Act. Echoing the words of the RCM president who was quoted as saying*" if we lose control of our education, we lose control of our profession"* the ARM took the view that this had indeed already happened. A new Act was called for which would

> *"set up a new midwifery body, provisionally entitled the Central Midwives Council. This body will be responsible for registration, education and training, setting and improving standards of practice and professional conduct. In effect, midwives will be answerable to their peers, and no longer part of the UKCC"* (Midwives Legislation Group 1990a).

The work of this group has produced a Draft Midwives Act (Midwives Legislation Group 1990b).

The argument for a new Midwives Act rests on the belief that midwifery is a profession, distinct from nursing and medicine and therefore should be self-regulating and have control over its own education. Where previously doctors dominated the CMB, nurses are seen to dominate the present structure within which midwives are a minority group. The RCM in 1990 established a Commission to conduct its own review into the strengths and weaknesses of the 1979 Act. The Commission

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17 Education Officers have responsibilities in the validation and approval of training courses.

18 Approval is ratified by the Midwifery Committee of the ENB who may, if they so wish, carry out their own visits to a centre.

received evidence, which they described as *"disappointing"* (RCM 1991:21), from midwives who had served as members on the statutory bodies, representatives from the RCOG, RCGP, consumer groups and practising midwives. The review concluded that the Act was generally accepted but that what was deemed *"all matters relating to midwifery"*, and which therefore under the terms of the Act required consultation with the Midwifery Committees, was open to interpretation (and therefore dispute). This was illustrated by the National Boards' handling of the management restructuring which went ahead without the support of the Midwifery Committee. Clearly in the Commission's view, some gains had been made for midwives under the 1979 Act especially as they were no longer controlled by a statutory body dominated by doctors (ie. CMB). They concluded that

> *"while no more perfect than any legislation can ever be the Act itself is considered generally acceptable and workable. During its considerations the Commission has inevitably been aware of a desire among some midwives for entirely fresh legislation which would remove midwifery from its present shared overall structure and revert to individual legislation. The strong majority view of the Commission, although not requested in its terms of references, is that this is neither practicable at the present time nor as yet proved to be desirable"* (RCM 1991:25).

So according to the RCM, the statutory powers of the Midwifery Committees could secure an acceptable degree of control for midwives over their own practice and education within the structure established by the 1979 Act. Its conclusions indicated a divison of opinion within the midwifery profession about the relative advantages of new legislation.

In other respects the statutory arrangements have been considered unsatisfactory and while the RCM had conducted its own review, as part of the Government's review process of non-departmental public bodies, between 1988 and 1989 an earlier review of the statutory bodies had been carried out by Peat Marwick McLintock management consultants. They

> *"identified a number of factors concerned with organisational arrangements which (they) believe inhibit the efficiency and effectiveness with which the statutory bodies are able to discharge their responsibilities"* (Peat Marwick McLintock, 1989:ii).

According to them these inefficiencies related to an unclear division of responsibility between the Council and Boards, duplication of their work and little direct accountability to the fee paying practitioners (nurses, midwives and health visitors). The committee system was itself considered *"cumbersome"* (Peat Marwick McLintock, 1989:pii). They made recommendations in three areas: professional conduct, education and training, management and organisation. Some were subsequently implemented following revisions to the 1979 Act in 1992 (Nursing, Midwifery & Health Visiting Act 1992). Others were superseded by the Government's Working Paper 10 on Education & Training discussed below in section three of this chapter.

The Peat Marwick McLintock report identified a major constraint on change as *"tribalism"* between the professions which *"is a strong element within their culture and it will take more than legislative change to remove it"* (Peat Marwick McLintock, 1989:para 2.7)[19]. Yet while these remarks indicated that it might be desirable to remove this constraint, the review was itself constrained by the Government in considering whether or how this might be achieved for, *"we were asked explicitly in our terms of reference not to challenge the principle of the professions' self-regulation."* (1989:viii). Since the authors placed on record that this requirement presented them with no difficulties because they supported the principle and considered it to *"work well"*, it is hardly surprising that their recommendations did nothing to enhance the status of the Midwifery Committee or increase its powers. In spite of their criticism of the committee system and a recommendation to *"simplify and streamline"* committee structures (Peat Marwick McLintock, 1989:29), for them, the midwifery profession's ability to be self-regulating was satisfied within the present legislation. They therefore saw no need for change and in any event, on its own, legislative change was deemed ineffective. Yet following the Government's response to this review, Ratcliffe (1991) argued that the future of the national boards is in considerable doubt and the demise of professional control over nurse (and by implication - midwife)

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19 Some features of this "tribalism" were identified - *"midwives are still very conscious of their "different" and "minority group" status"* while health visitors and district nurses were seen as "relatively happy". In addition, the representation by the three professions (Nursing, Midwifery & Health Visiting) was not always seen as in the interests of specialist minority groups (eg.mental handicap).

education, was signalled by the Peat Marwick McLintock report, a claim which will be considered in more detail below.

We have seen how legislation regulates midwifery practice and education through the work of the statutory bodies.This seems to be a double edged sword as Devries (1982) suggested. The establishment of the Midwifery Committees is itself a distinctive aspect of the structure since all other groups are subsumed under the umbrella of nursing. (eg.health visitors). Yet the powers of the committees evidently are circumscribed by the way in which their remit is understood and enacted.

2.2 The role of the midwife

The right to self-government is closely linked to autonomy. Many midwives claim they are (or, given the opportunity, should be) "autonomous practitioners". Their practitioner status is enshrined in law and their claim is based on these laws . Under the provision of the 1979 Act (following from previous Midwives Acts - see appendix 2), attendance at a birth by any person other than a registered midwife or medical practitioner was affirmed as illegal (1979:para 17). The role of the midwife is legally defined at the international, European and national level. It is useful to consider how far these definitions are consistent. Consistency could be seen as evidence of a widespread consensus with regard to what counts as "a midwife" and what midwives do.

In their work for the World Health Organisation (WHO), Oakley and Houd (1990) present a definition agreed by that organisation in 1961:

> *"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervisions, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of*

medical assistance and the execution of emergency measures in the absence of medical help.She has an important task in health counselling and education, not only for the patients but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service" (Oakley & Houd,1990:1 emphasis added).

According to Oakley and Houd, this broad definition encompasses a wide range of *"slightly different definitions of midwifery in different countries"*, a few examples of which are illustrated by them. They conclude that *"Although the wording and the specified period of care differ, the message is clear: the midwife gives independent care to women who have normal pregnancies and births"* (Oakley & Houd,1990:2 emphasis added).Evidently, what counts as a midwife and her sphere of responsibility rests on this distinction between "normal" and "abnormal" pregnancy and birth It is in relation to the *"women who have normal pregnancies and births"* that midwives are able to the give *"independent care"*. Witz (1992) refers to this as *"a demarcationary strategy of de-skilling"* on the part of medical practitioners, which effectively defined the boundary between them and the midwife in the late nineteenth century. Since, on detection of the "abnormal" the midwife's responsibility alters and her task is to refer to a doctor, this represents,according to Witz's analysis, significant concessions (an accommodative strategy) made by midwives then, which resulted in their continuing subordination to doctors following the first Midwives Act in 1902. This is further illustrated by a close reading of the European Community Directives (EEC Directives)which came into force in 1980.

Article 4 (see appendix 3) requires European Member States to ensure that midwives:

> "*diagnose pregnancies and monitor normal pregnancies; to carry out the examinations necessary for the monitoring of the development of normal pregnancies;*" [and] "*to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate...*" (EEC, 1980:article 4, emphasis added)

..... taking emergency measures in the doctors absence. Although the division of labour between midwives and doctors is centred on the distinction between :"normal" and "abnormal", it is midwives who are called upon to recognise the "abnormal" and diagnose pregnancies "at risk". Furthermore the midwife is required "*to carry out treatment prescribed by the doctor*" . It is this deference to the doctor in cases of "abnormality" and in carrying out prescribed treatment which continues to threaten the independent or autonomous status of midwife practitioners. As Witz points out, the extent of the midwives "independence" is strictly limited.

In the United Kingdom the UKCC produces the rules for midwifery practice and education. The Midwives Rules are legally expressed in the form of statutory instruments which set out the responsibility and sphere of practice for midwives.

> *"A practising midwife is responsible for providing midwifery care to a mother and baby during the antenatal, intranatal and postnatal periods. In any case where there is an emergency*[20] *or where she detects in the health of a mother and baby a deviation from the norm a practising midwife shall call to her assistance a registered medical practitioner, and shall forthwith report the matter to the local supervising authority in a form in accordance with the requirements of the local supervising authority".*(UKCC,1991:19 Statutory Instrument 1986 No786 Rule 40).

The rules are elaborated in the Midwives Code of Practice where we find

> *"The responsibilities of the midwife and the doctor are inter-related and complementary. However, each practitioner retains the clinical accountability for her own practice. The necessary degree of co-operation can only be ensured by a mutual recognition of the respective roles of midwives and doctors and those of others who may participate in the care of mothers and babies. Such co-operation and recognition should enhance the standard of care"* (UKCC,1991:5 para3.3.2).

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[20] We find "emergency" is defined within the Rules as *"any illness of the mother or baby or any abnormality becoming apparent in the morther or baby during the antenatal, intrantal and postnatal periods"* (UKCC,1991:5 SI 1986 No 786 Rule 27)

Mutuality hardly best characterises the relationship between midwives and doctors as construed by the 1992 Health Committee report on the maternity services where adversarial *"rivalries"* were indicated. On the issue of "accountability" the RCM interprets these rules, pointing out that

> *"there is no requirement in law for the midwife to involve a medical practitioner in the care of clients if she is working within the competencies stated in (the training rules). However, where there is a deviation from normal in the mother or baby or where there is an emergency, the midwife is required by the Rules to call to her assistance a registered medical practitioner. She may therefore offer her services privately and independently of a Health Authority or medical control although very few do this at the present time"* (RCM date unknown:3).

So while the midwife is accountable for her own practice, in law a relationship of dependence on a) being able to identify and differentiate between "normal" and "abnormal" and b) deference to a medical practitioner in "abnormal" circumstances, is established.

The midwife continues to be accountable for her practice *"even with a named consultant and/or GP in charge of the case"* (RCM date unknown:5).The law is called upon to justify the midwife's claim to independence because she has a legally defined sphere of responsibility and practice within which she works unsupervised and with an independent legal and professional accountability for the care she gives. However in effect, the conditions under which referrals are made to medical practitioners, and where the doctor takes charge of the case, the midwife's claim to independence and autonomy appears weakened even though she remains accountable for her own practice.

The RCM based their evidence to the Health Committee on the principle of

> *"the right of midwives to practise their profession in a system which makes full use of their skills to provide full clinical care thoughout pregnancy, in labour, at delivery and in the postnatal period and which respects their legal accountability"* (HoC 1992:para 180).

A *"right"* to practise was rejected by the Committee in so far as it sought to override the rights of other groups but generally there was an

acceptance that as a group, midwives skills are under-utilised. This was also the conclusion of a study which looked at the Role and Responsibilities of the Midwife in 1983 (see Robinson 1985 for a summary of this study). Robinson et. al.(1983) sought to provide a descriptive analysis of midwives' work and they concluded that there was considerable overlap between what midwives and doctors do in midwifery care. Drawing on this research and the work of Garcia et. al. (1985) Oakley & Houd, in their discussion of *"what midwives do"* suggested:

> *"In the United Kingdom for example, midwives are often allowed more autonomy by the laws and statutes governing their practice than by their particular institutional setting. This complicates clinical decision making for midwives, who are held legally responsible for their actions even when their treatment of an individual woman is determined by local hospital policy and goes against the midwife's own clinical opinion. In such cases, a midwife may be called on to defend a decision that was not hers in the first place"* (Oakley & Houd 1990:52).

Here we see the responsibilities of midwives <u>in law</u> being viewed in opposition to constraints imposed on her by institutional policies and practices. It further illustrates how the law is used as a justification for re-examining those policies, and re-instating the midwife's autonomy.

According to Robinson (1990:72) an *"erosion"* of the midwives' role may be traced back to the inception of the National Health Service and is directly attributable to increased *"medical involvement in normal maternity care"*, (see also Morrin 1982 who asks whether midwives are *"in danger of extinction"* because *"science has overtaken the midwife"*). Changes in the organisation of maternity services in the 1960's and 1970's and management structures in the 1980's further contributed to this erosion. Collective action has been called for as midwives exhort their colleagues to acknowledge the part they play in their own subordination to medical practitioners, and in allowing their role to be eroded (Brain, 1986; Rogers, 1991; Walker, 1991). These writers argue that the present legal framework provides the necessary backing for midwives to practice autonomously and that by seizing power, *"the dream can become the reality"* (Walker 1991). The challenge is to assert the midwives legal right to act as the *"expert in normal childbirth"* (Walker 1991), and to promote a midwifery model of care which is

currently undermined by *"the settings and conditions of modern obstetric care"* (Oakley & Houd 1990:58), a view consistently reiterated by the ARM (1986).

2.3 Interim conclusions

This section has examined how legal discourse constructs "midwife" and provides a legal, discursive framework within which what a midwife is, and what she does may be understood.In many ways the law may be seen as permissive - it allows for a sphere of responsibility and practice to be defined and provides statutory bodies to regulate and monitor midwifery practice and education. However interpretation of the law is a matter for further negotiation and debate. While there appears to be widespread consensus that midwives should be able to regulate their own practice and education, and are "experts in the normal" the means of achieving this are evidently contentious. While midwives may have a **responsibility** to care for women defined as having "normal" pregnancy, and/or childbirth, it would seem they have no **rights** in this respect. Instead, the rights of women to choose the type of maternity care they prefer are more readily recognised. As a justificatory strategy for invoking more power and control in caring for women, the law ultimately provides less support than perhaps first appears. The view (expressed by the RCM), that changes to current legislation would do little to enhance midwives' position acknowledges this. So far I have discussed conflicts in the organisation of maternity services and the legislative context of midwifery practice. In the next section I will examine how proposals for change in the area of education,were seen as presenting further threats to the autonomy and status of midwives.

3.0 The Education Debate

In any account of midwifery education today the conflicts and controversies of the past are reconstructed. Since 1916 there have been two routes to midwifery, one was direct entry to a midwifery course, the other was a shortened course for those already registered as nurses. [21]. Appendix 4 sets out the policy developments in midwifery education and identifies the difference in length of training for the two routes. In 1981 training was extended to three years for direct entrants with an eighteen month post-registration course for nurse entrants. This brought the United Kingdom in line with other European countries (EEC 1980). This section examines accounts of developments in midwifery education since that time for during the 1980's a vigorous debate about the future of midwifery education emerged, a debate that led to the developments which this study and the evaluation project examined.

There was a decline in the number of direct entrants to midwifery until in 1983 only one midwifery school offered such a course. A number of explanations have been given for this. These generally focus on the lack of career opportunities for those without dual qualification (ie. both nurse and midwife registration) and discrimination against direct entry midwives (ARM 1980, 1981; Ball 1982; Downe, 1986). According to some commentators, direct entry courses were of poor quality and the intense demand placed on service for practice placements in a three year course were seen as contributing to this decline (Radford & Thompson 1988a). Defenders of direct entry courses, as we shall see, hotly contested the view that midwives trained this way were in any sense inferior. So, against a background of patchy support for and provision of direct entry courses, discussions about the future of midwifery education during the 1980's became focused on the question of whether midwives should train first as nurses, and were related to dissatisfaction with the position of midwives in the maternity services already discussed above. It was suggested that

> *"dissatisfaction with the current role and status of the midwife underlies the resurgence of interest in direct entry : the direct entrant, so long seen as an inferior breed of midwife (compared*

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21 There are two qualifications in nursing one leading to registration (RGN), the other to enrolment. Enrolled nurses (EN) Since 1981 EN's have been unable to enter midwifery training.

with her jointly qualified sister), is now proposed as the guardian of the future of midwifery". [Direct entry midwives] *"are thought to be less tolerant of the encroachment of the medical model of sickness into normal maternity care, less willing to conform to the norms of the doctor-nurse relationship, and therefore more able to accept the responsibilities demanded of an independent practitioner"* (Curtis, 1986:4).

According to Curtis, writing in 1986, this "U-turn" indicates the midwifery profession's efforts to reassert a separate identity. It seemed that direct entry was to be supported on ideological grounds since it asserted a distinct identity for midwives and produced a practitioner who was better suited for "independent" practice. However, while the 1979 Act was seen by critics as marking a particular stage in disenfranchising midwives, later events in the education arena represented a more fundamental attack. Specifically the UKCC Project 2000 proposals (UKCC 1986) were controversial since they appeared to subsume midwifery into the nursing profession. Many midwives saw this as an attack not only on the ability of midwives to control their profession but on their professional identity. So how was a midwife "identity" constructed in this education debate?

The identity of midwives is considered distinct from nurses in two important ways. First midwives have a **statutory** responsibility for pregnant and labouring women, they are required (and enabled) under the law to act independently (see above 2.0), whereas the nurse is thought to act under the direct supervision of the doctor. Secondly, the midwife is concerned with "normality" and "health" whereas the nurse is seen to be traditionally oriented towards "abnormality" and "illness" Flint, a well known midwife, in her article titled *Should midwives train as florists?* criticised the notion that midwives should train as nurses (and argued that there was no more justification for this than for them to train as florists). She put it like this:

"Midwives don't have patients - they are with women as they go through a huge and life-changing experience. They are partners and colleagues. They work as a team, but a team of equal decision makers. The woman is not ill, she is going through a normal physiological process, like having your bowels open, or breathing, or making love" (Flint, 1986).

A motivating force for setting up the ARM was *"the apparent trend towards 'maternity nurse' status in ...training"* (appendix 5). The student midwives instrumental in establishing the ARM were keen to support direct entry midwifery courses as a means of distinguishing between nurses and midwives and ensuring that midwives were enabled to develop and use their skills to the full. An ARM Direct Entry Working Party (convened in 1983) set themselves the explicit task of promoting the direct entry route to midwifery qualification. Although there was some dissatisfaction with the quality of direct entry courses at that time, there were strong feelings that direct entrants to midwifery, often older women compared to the nurse entrant, had much to offer, not least because they had a distinct approach to midwifery. One direct entrant explained

> *"I hate ill people, so general nursing is not for me. Midwifery is not dealing with a sick patient, this is what makes it a completely separate craft from nursing"* (ARM, 1980).

A subsequent ARM newsletter elaborated -

> *"Perhaps most importantly midwives are the guardians of the normal in obstetrics. Since direct entrants have not spent three years caring for the sick and diseased, they are less inclined to look on childbirth as a pathological condition. They are orientated towards the normal and are more readily appreciative of the preventative role of midwifery, rather than the curative role in which a nurse is trained. Insisting that all midwives should be SRN's is contributing to the present trend of regarding pregnancy and childbirth as an illness from which women are delivered by obstetricians and nursed through by midwives, who are no more than obstetric nurses"* (ARM, 1981, emphasis added).[22]

According to this view the integrity of the role of the midwife as *"the guardian of the normal"* could be secured by having direct entrants to the profession. The identity of the midwife seemed inseparable from the means by which she was educated since caring for the healthy, rather than treating the pathological *"comes naturally to the direct entrant"*(Ball, 1982:12).

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22 State Registered Nurses -now referred to as Registered General Nurses (RGN).

The content of direct entry courses was closely examined by the Working Party to demonstrate that a quality midwife could be produced via direct entry courses and the extension from two to three years duration in 1981 was considered by them, an opportunity to improve these courses (ARM, 1982; Stewart, 1981). Although the regulations permitted direct entry to midwifery, the case for increasing the number of courses available was apparently argued only by a minority. While the ARM strongly advocated this approach on the grounds that midwifery was health focussed, they also argued it was "logical" because direct entrants were strongly motivated to become midwives and would remain in the job (Jennings 1982). In addition it was consistent with the European approach (see also Oakley & Houd, 1990:40) and cheaper than training someone as both a nurse and a midwife, especially as many nurse entrants returned to nursing after qualifying as midwives (ARM, 1981, 1985; Robinson, 1986a, 1986b, 1986c; Robinson et. al., 1992) (views reiterated by those involved in direct entry training Ball, 1982). Retention of midwives had been, and still is, a long lasting concern (Radford & Thompson, 1988).[23] The RCM were reported to be reticent about promoting additional courses (Jennings, 1982) and their general policy in the early 1980's was that *"midwives should be nurses first"* (Holmes, 1983).

The relocation of midwives in hospitals was seen, by some midwife commentators, as promoting the idea of midwives being obstetric nurses (Holmes, 1983; Curtis, 1986) while a shortage of tutors, lack of practical placements for students to gain experience and the high costs of providing a three year midwifery course (under the different funding arrangements for nursing and midwifery) were given as reasons for so few direct entry courses (ARM, 1985). But from 1985 there was a shift in thinking about nurse and midwifery education which was to develop into an energetic debate about the relative merits of the direct entry route.

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23 A principal aim of the evaluation project was to examine the workforce implications of the development of pre-registration midwifery education see Kent, et. al. (1994).

3.1 Proposals for change in midwifery education - a threat to midwives?

The publication of the Royal College of Nursing *Judge Report* on Nurse Education and the 1985 ENB Consultative document *Proposals for Change* (ENB, 1985) in education and training marked a significant turning point. The key proposals were:

- There was to be a shift in all nurse education to focus on "health", and "direct entry" to all specialities in nursing was proposed - Mental Nursing, Mental Handicap, Paediatric Nursing, General Nursing (Hospital), General Nursing (District), Midwifery, Health Visiting.

- All courses would be three years duration.

- There would be a common core in health.

- Collaborative links would be established between schools of nursing and schools of midwifery and institutions of higher education.

- Students would be supernumerary[24]

The ARM was supportive of these proposals in principle (MacKeith 1985) and there was widespread agreement that a common core programme could be acceptable and that direct entry midwifery should be increased (Radford & Thompson 1988:44).

Initially the ENB proposals were welcomed as a recognition of the claims made for direct entry midwifery courses. It was even suggested that the proposals for nursing followed the midwifery example. However in the Judge Report the relationship between midwives and nurses was considered more *"prescriptive"* as it appeared to subsume midwifery as a specialism of nursing (Newson, 1986). The UKCC document Project 2000 (UKCC, 1986) followed and it provoked a vigorous response from midwives. A two year foundation course was

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24 "Supernumerary" is most frequently taken to mean that students are not part of the workforce and are therefore extra to the unit staffing requirements. In addition this is linked to the transfer of funding so that students are no longer salaried employees. For further discussion of this see Kent, et. al. (1994).

proposed followed by a one year *"branch programme"*[25]. Five branches were identified here one of which was midwifery. The reduction of the midwifery content to one year was considered a retrograde step by some commentators (eg.Scruggs, 1986) and the ARM stated they wanted no part of it (Hughes & Parker, 1986). Others pointed out that the proposals stressed a need to see each qualifying programme as of three years duration (MIDIRS, 1986). Midwives were asked to consider an experiment of three year midwifery programmes, and a new list of competencies set out in new Training rules which would supersede the existing Midwives Rules. The UKCC accepted *"that midwifery is a profession different from, but complementary to nursing"* and claimed that Project 2000 with

> *"the CFP* [Common foundation programme] *route offers many of the attractions that the direct entry lobby seeks and avoids some of the disadvantages"* (UKCC, 1986:para 6.33).

Some of the UKCC P2000 reforms were accepted - notably the links with higher education, the focus on health, the supernumerary status of students and shared learning between professions where appropriate (Tickner, 1986; RCM, 1986; Newson, 1986). However, many of the proposals were considered unacceptable. The RCM recalled the legislative framework of the midwife's role to justify a rejection of the notion of a *"new animal"* in midwifery as envisaged by the Project proposals. In addition, the competencies of the midwife were seen by the RCM to be undermined since the proposals did not specify the area of responsibility for midwives in antenatal, intranatal and postnatal care. Neither did they recognise the level of competency required of midwives at registration.

While certain proposals were accepted, in so far as Project 2000 was seen to represent a fundamental attack on midwifery as a separate profession it was rejected outright. The distinctiveness of midwifery as a separate profession was expounded vehemently by a midwife who later took up post as the senior midwife at the Department of Health:

> *"Firstly midwifery is a separate profession not the seventh branch of nursing. Second, there is already a three-year training*

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25 This was subsequently reduced to 18 months.

> *course for midwives based on agreed EEC directives and geared to the midwives' needs, producing a practitioner on qualification. Beyond doubt there is a need to increase the number of direct entry courses available to train midwives. What is proposed may be right for the future preparation of nurses but not for midwives"..."Wake up! We must not allow ourselves to be engulfed and swamped by these proposals, which would not produce the midwife practitioners we need and would, once and for all, see the demise of midwifery as a separate profession"* (Greenwood, 1985 cited in Curtis 1986:22,emphasis added).

Opinion was divided because others saw the changes as providing midwives with new opportunities (Roch, 1986; Newson, 1986) which, if carefully negotiated, could further enhance midwifery education. As another midwife observed

> *"the common foundation programme is reputedly to be based on health and would contain biological and behavioural sciences, communication skills and social policy, all of which are subjects perfectly suited to a potential midwife"* (Pope 1987:57, emphasis added).

Midwives did not speak with one voice but there were those, notably within the ARM, who proposed that midwives should go it alone (MacKeith, 1986; ARM, 1986). The need to come up with an alternative plan to Project 2000 was considered necessary (Dickson, 1986:68).

The RCM produced its own report on *The Role and Education of the Future Midwife in the United Kingdom* in 1987 which did not address the particular issue of direct entry midwifery education explicitly, but outlined a draft curriculum based on its own educational ideology and supporting the principle that midwifery programmes should be three years in duration. The document neither ruled out the possibility of a midwifery course as part of Project 2000, nor advocated a quite separate training for midwives. It was ambivalent. It did however reinforce the statutory responsibilities of the midwife, the distinct "professional identity" of midwives, and the need to retain *"the separate and distinct competencies for midwives"* (RCM, 1978:6). As Radford & Thompson (1988a:46) point out, no reference was made here to post-registration midwifery education (the shorter course for nurses) although elsewhere the RCM had supported its continuation (Tickner, 1986:35).

During the consultation process around Project 2000 the key areas of disagreement were - the one year length of the midwifery content which was considered insufficient time to gain clinical competence and confidence; the idea of midwifery as a "branch" of nursing; the shared list of competencies which were seen as too general and the single registration. The level of competence required for midwives at the point of registration was thought to be more easily equated with the notion of the "specialist practitioner"[26]. The RCM argued that no *"new animal"* was needed in midwifery.

The areas of agreement were - that direct entry to the professions was desirable (ie.no need to train first as a nurse); that this would reduce the cost of training a midwife; and that there was potential for shared learning in common areas of knowledge (although midwives considered this may not necessarily be at the beginning of the course). Supernumerary status for students and links with higher education were also supported. Importantly the distinctiveness of the midwife as "the guardian of the normal" was weakened by the "health focus" of the new nurse practitioner envisaged in Project 2000. Clearly to pursue the argument that midwives were distinct because they emphasised "health" and "normality" could not, on its own, support the case for a separate midwifery course, so the debate shifted emphasis to the independence of the midwife practitioner, and her specific level of competence, responsibility and decision-making as the key features of a midwife professional identity. Strategically this was successful as Project 2000 dropped midwifery from the branch programme.

On the surface at least it seemed midwives' voices, although divided in certain respects, had been heard. Yet from the evidence of earlier arguments for direct entry and legal discourse, midwives' ability to identify themselves as professionals relies on definitions of "normal" and "abnormal", "health" and "illness". In the words of Curtis

> *"the definition of normality is fundamental to the role and responsibilities of the midwife, and the evolution of abnormality has had far reaching effects upon midwifery"* (Curtis,1986:36).

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[26] The specialist practitioner was depicted in Project 2000 as a level of advanced practice post-qualification. Midwives saw themselves as specialist practitioners which, in terms of the proposals was not a first level qualification.

So while the education debate was reframed in terms of "professional ideology" its basis remained essentially the same - that the construction of "midwife" depends on a particular view of midwifery as caring for "normal", "healthy" women.

In the autumn of 1986 the ENB sought midwives' opinions on developing separate direct entry midwifery courses and widespread coverage in the midwifery press reported enthusiasm for more of these (Scruggs, 1986b; Midwives Chronicle Editorial, 1986a; Editorial in Midwife, Health Visitor and Community Nurse, 1986b). The ENB and Department of Health subsequently funded a study to promote *Direct entry: A preparation for midwifery practice'* (Radford & Thompson 1988). This study followed earlier research into midwifery education that had focused on direct entry courses which I will now discuss in a little more detail. Both of these studies were the forerunners of the evaluation project later funded by the Department of Health and this research.

3.2 Research into midwifery education -towards the development of the pre-registration approach.

The ARM Direct Entry Working party had conducted an earlier survey in 1985 to assess attitudes towards direct entry midwifery training (Downe 1986a). While seeking to identify the reasons why midwifery schools had no direct entry course, or were interested in starting one, their study sought to dispel ignorance, myth and prejudice about direct entry training (ARM, 1986b; Downe, 1986b, 1987). In particular Soo Downe, (well known for her views on midwifery education and a founding member of the ARM, who trained via the direct entry course in Derby), has forcefully argued that beliefs about a lack of applicants to direct entry courses, poor career prospects for direct entry midwives and insufficient tutors are ill-founded Her work constructs direct entry midwives ("DEs") as distinct from other midwives and nurses in certain respects.

> *"DEs do not only threaten the midwifery establishment to some extent: along with the gradual development of self-confidence in midwifery as a whole. DEs have often been rather uninhibited about challenging the decisions and practice of obstetricians - a challenge which is not always undertaken by nurses trained in a*

strict mode of 'doctor knows best'. This ability to percieve oneself as truly an independent practitioner in one's own right is perhaps one of the major contributions DEs can give to English midwifery, alongside the growing self-awareness of midwives as a whole. This is not so much to confront doctors but to work with women towards returning them to the centre of their childbirth experience, and to regain our rightful status as experts in normal midwifery.....Education and specifically DET (direct entry training), has to be a major route towards facilitating this change" (Downe, 1987, emphasis added).

For Downe and other ARM members, research into midwifery education is premised on the need for midwives to be "experts in normal midwifery" and direct entry courses are a means to achieving this. This research, extended to carry out a second survey of midwives in 1987 with support from the Iolanthe Trust, sought to present the "facts" about direct entry and took as its starting point that the role of the midwife is the guardian of normal midwifery. Downe recognises that direct entrants' lack of nursing background is used as an argument both for and against direct entry midwifery training but rejects the idea that they receive inadequate training in caring for "abnormal" cases. According to her the emphasis of the direct entry approach may be seen as "normalising" pregnancy and childbirth.(Downe 1986b).[27]

The Radford & Thompson study set up by the ENB and what was then the DHSS ran for one year from April 1987. It had two primary objectives:

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[27] A view Downe reiterated in 1990 in response to her experiences of newly developing pre-registration midwifery courses since the (apparent) rejection of P2000 by the profession. Expressing concern about the form of these developments she wrote

> *"One of the fundamental roles of the midwife is as the guardian of normal midwifery and advocate of the pregnant and labouring woman. The relationship of midwifery to obstetrics is a vital element in this role. In an age of rapid technological advance, it is even more important that midwives are fully and completely grounded in midwifery so that they can be confident in both practical skills and in their beliefs in the essential normality of the childbearing process"* (Downe, 1990).

Would these new courses enable midwives to fulfill this role after all? Indeed how far is the purpose of these courses to promote the kind of midwife practitioner envisaged in these remarks?.

> *"1. To collate available information on direct entry (and relevant other subjects), to identify the gaps in existing information, and to try and fill these gaps.*
>
> *2. To promote the development of direct entry courses, create greater awareness of direct entry, discover the inhibiting factors, and to provide useful tips on the establishment of such courses"* (Radford & Thompson,1988a:5).

Evidently there was already a commitment by the ENB and DHSS to promote direct entry courses. Radford & Thompson report that in 1987 the DHSS recommended to Regional Health Authorites that they should have at least one such course (Radford & Thompson, 1988:50). They emphasised that a decision in favour of direct entry had already been taken and the purpose of their research was to assess the factors affecting implementation of that decision (Radford & Thompson, 1988:180). In the event, the second of the research objectives

> *"could not be achieved"* [because] *"the investigations progressively showed that the issues constraining direct entry training were more complex than initially anticipated"* (Radford & Thompson, 1988a:7)

and these would require intervention by the statutory bodies or *"a consensus amongst midwives as to the future direction of the profession"* (Radford & Thompson, 1988a:8).

It seems that initially such a consensus had been assumed, by the ENB at least, if not the researchers themselves although the report does suggest that there was widespread support for direct entry midwifery training (Radford & Thompson, 1988a:181). However the reasons for this support were, according to Radford & Thompson either pragmatic or ideological (Radford & Thompson, 1988a:101, 1988b:54; Grant, 1988). While *"pragmatic"* arguments centred on workforce issues and cost, *"ideological"* arguments highlighted the "health" orientation of the direct entrant to midwifery and the likelihood of resistance to hierarchical management. While apparently *"educators and planners alike used both groups of arguments"* (Radford & Thompson, 1988a:101) elsewhere in the report Radford & Thompson suggest that Regional Health Authorities were more concerned with pragmatic arguments

while midwife teachers supported direct entry on ideological grounds (Radford & Thompson, 1988a:173).

Although it was suggested that the midwife teacher is likely to have considerable difficulty in winning the case to set up a direct entry course on ideological grounds alone, it seemed that they would carry the day. Since:

> *"Despite the persuasiveness of the pragmatic arguments the motivating power of the ideological perspective carries more weight with the profession in the long run, for it seems that the whole issue is linked to a bid to re-establish the midwife as a practitioner with a distinct professional identity"* (Radford & Thompson, 1988a :104).

It is not clear from this how far the midwife teachers were considered to represent the views of the profession as a whole and of course the idea that workforce issues were merely practical or technical problems belies the management ideologies which define them as important in the first place. So the pragmatic/ideological split is somewhat misleading. Furthermore, hegemony amongst the midwife teachers is not as widespread as perhaps indicated in some parts of the report since Radford & Thompson also say that some tutors would have been happier to adopt P2000 and a common foundation programme in modified form, rather than go it alone with separate training for midwives (Radford & Thompson, 1988a:115).

For their research study the diversity of perspectives was a problem and the authors were unable *"to ascertain where the truth lay"*. They concluded, like Downe, that *"myths, generalisations and prejudices abounded"* and they sought to distance themselves from the views presented (Radford & Thompson, 1988a:163,164). Readers were invited *"to draw from it what they wished"* (Radford & Thompson, 1988a:180). Such an invitation was no doubt intended to absolve the authors from any charges of partiality. The decision to develop direct entry courses stood. Confined to examine questions about how best to implement a policy decision the research task had been defined as a technical, rather than a political one. Radford & Thompson were faced with political processes that went beyond the "pragmatic" difficulties of setting up new courses. Although they perhaps underestimated the political potential of their report, they were unable to address more

fundamental issues about direct entry as a preparation for midwifery practice. Following Robinson et. al (1983), they reproduced the statutory definitions of the midwife role, arguing that this precedes the requirements for midwifery education programmes. But the extent to which midwives' actual or designated role was, or could be, achieved was also considered beyond their remit. The ENB's decision to promote direct entry subsequent to what had been described as the midwifery profession's rejection of P2000 had already set the agenda. Even so, Radford & Thompson raised questions about how widespread the consensus was. Although the study was *instrumental in extending the* demand for direct entry courses, it might have also raised questions about the political will to proceed with the direct entry approach.

In 1989 the Government's Working Paper 10: Education & Training stated

> *"the Government wishes to see an expansion of direct entry midwifery, which is more cost-effective in the long run...."* (DoH 1989:para 6.7)

and the funding arrangements for training were redirected to Region Health Authorities (RHAs)who would become purchasers of midwifery education (see appendix 6). Workforce considerations, (the need to ensure a supply of suitably qualified midwives) and the potential cost advantages of pre-registration midwifery courses were given as the principal reasons for these developments (DoH 1989,para 6.4); and the links with higher education were to be strengthened for all health courses. The case for change was couched in "pragmatic" terms and invoked none of the ideological reasons for pre-registration midwifery. Professional ideologies were subsumed under managerial imperatives. At about the same time the Department of Health announced its intention to provide pump priming monies for the setting up of new pre-registration midwifery programmes at fourteen sites. It was originally expected that this would encourage each of the fourteen RHAs to develop the pre-registration approach though in the event two regions did not recieve monies (Kent, et. al 1994). From this time what had previously been called 'direct entry' courses were formally redefined as pre-registration programmes which would be at diploma or degree level and have links with higher education. Students would be supernumerary and each programme would be at least three years in length. However, attitudes towards the pre-registration approach were informed by these

earlier debates about the direct entry courses and the controversy around the Project 2000 proposals.

In addition to the pump priming monies made available to seven sites in 1989/90 and another seven in 1990/91, the Department of Health awarded research monies to Maggs Research Associates, Bath, to carry out *An Evaluation of Pre-Registration Midwifery Education in England.* This three year project began in December 1991 and I was recruited to work on it soon after. The project began with two research questions:

1. *What are the views of pre-registration student midwives, midwives, educationalists and service-based managers of midwifery services about midwifery education?*

2. *What are the workforce implications of pre-registration midwifery education?*

The approach to evaluation adopted is described briefly in the next chapter which explains how group inquiry was set up as part of that project in order to explore in more depth the students' views of the pre-registration approach and their educational experiences. The evaluation report was completed in December 1993 and submitted to the Department of Health. It was subsequently renamed *Direct But Different - An Evaluation of the Implementation of Pre-Registration Midwifery Education* (Kent, et. al. 1994) and further research was sponsored by the ENB to evaluate the outcomes of pre-registration midwifery education and other aspects of the content of these programmes. These additional studies have not yet been completed..

3.3 Conclusions

In this chapter I have provided a context for understanding the students views of pre-registration midwifery education and their experiences of each diploma programme on which they were enrolled. This context was explored in the three key areas discussed here- 1) the provision of maternity services, 2) the legislative framework for midwifery practice and education and 3) the changes in education which have led to the development of the pre-registration approach. In each area I have examined contemporary debates about what it means to be a midwife. This has often been expressed with reference to normative assumptions about the role of the midwife, claims by midwives to have knowledge and skills that are distinct from what either obstetricians or nurses do, and a view of childbirth as a normal and natural process which I have referred to as a midwifery model. This midwifery model was contrasted with a medical view in the context of service provision and with a sickness model of nursing in the education debate. The development of pre-registration midwifery education programmes was seen as continuous with earlier direct entry courses and supported on both ideological and pragmatic grounds in the light of changing conditions for educational provision. Central to this discussion have been themes of professional power and a midwife identity and a belief that midwives are best placed to care for parturient women. The students' own accounts of *becoming a midwife* will return to these themes and in chapter five I will explore them in the light of *Group inquiry*.

CHAPTER 2

Reflexive sociology- a theoretical and practical possibility

Introduction

In writing this chapter I have two aims. First to locate this research within broader debates in the sociology of knowledge and second to outline the group inquiry approach. This will enable me to identify, in the light of this inquiry, the key issues that arise using 'a sociological voice'. As a reflexive project these theoretical issues will be seen to have relevance to an understanding of both what the students had to say about becoming a midwife and the process of inquiring together. (This will be made clearer in chapters five and six respectively). In this way I hope to demonstrate how reflexive sociology may become a theoretical and practical possibility.

The evaluation project was set up in order to seek the views of those involved in pre-registration midwifery education. We recognised that there were multiple perspectives which could be included in the evaluation and an approach was needed that would take account of this. Following earlier evaluation theorists this meant adopting a liberal democratic view of the evaluation process for according to House (1980) all approaches to evaluation derive from the ethics, epistemology and politics of liberalism. Evaluation was seen as *"a practical, particularistic, political and educative service"* (Simons, 1987) which could provide insight into the political process of policy formation. Rather than assuming we could assess how far clear, or rational, objectives set by policy makers at the top had been implemented, we began with a view of policy being formed at the bottom. This meant that instead of suggesting that certain outcomes had to be achieved and we were to evaluate how successful people had been in implementing them, we wanted to understand the dynamic processes of negotiation and bargaining which were shaping pre-registration midwifery education.[1] Of course there are certain regulations and guidelines within which pre-registration midwifery education takes place set out in chapter

[1] For this reason the renaming of the project to "An evaluation of the **implementation** of pre-registration midwifery education" (Kent, et. al., 1994) was, in certain respects, contradictory.

one, but these too were the product of political processes and, to an extent, open to interpretation.

Evaluation might also be seen as a tool of accountability and as part of the evaluation team, I wanted to promote democratic accountability (Day & Klein, 1987). Since we could not assume that different groups had the same concerns or interests in relation to pre-registration midwifery education (Radford & Thompson, 1988), our aim was to explore those divergent views and perhaps contribute to the development of a consensus. We wanted to inform debate and enable, or educate, others to decide the way forward for midwifery education. This did not imply that our role as evaluators was simply a technical one or even that of passive observers (Guba & Lincoln, 1989) since evaluators are themselves *"embroiled in political processes"* (Simons, 1987). Neither could evaluators be seen as neutral *"information broker*[s]" (MacDonald, 1993) since the interpretative work needed to make sense of what participants in the study told us, placed us firmly within a specific socio-economic, political and historical context.

The approach we adopted identified "*stakeholders*" in midwifery education- the department of health, the regulatory bodies responsible for midwifery education, the professional bodies, health service managers, and consumers of maternity services, in addition to those directly involved in midwifery education -education managers and teachers, midwife managers and practitioners in midwifery service who had responsibility for providing practical experience. Consistent with *"responsive evaluation"* (Stake, 1975) we sought the views of all these groups but in *group inquiry* I focused on the students' accounts of becoming a midwife[2]. I wanted to examine the ways in which the pre-registration approach to midwifery education was understood by them and their interpretation of the relevant regulations and guidelines. This would enable me to draw attention to the ways in which they were able to participate in the processes of negotiation and bargaining that were shaping pre-registration midwifery education. My aim then was to consider how their accounts might be seen as contributing to the development of a consensus about the future of midwifery education and the midwives' role in the practice setting. For in so far as they were able to give

[2]Other students took part in the evaluation through the national survey and interviews in the other four case study sites. Their views are not included here but were reported in the evaluation report (Kent et al 1994)

voice to their concerns, the democratic intentions of the evaluation and group inquiry could be realised.

While the evaluation report discusses the views of other stakeholders (Kent, et. al, 1994), the focus of group inquiry and this thesis was the students at two sites where the evaluation was being carried out. The evaluation included all sixteen sites where pre-registration midwifery programmes had begun by October 1991. Following preliminary visits to these sites to agree access for the evaluation, six case study sites were selected for in-depth fieldwork (Kent & Maggs, 1992; Kent, 1992) and it was agreed that a national survey would be carried out at the other sites . The six case study sites were selected using criteria that related to those features thought likely to influence and shape the experiences and views of participants in the evaluation (see appendix 7). A 'case' was defined as a set of institutions providing pre-registration midwifery education and included the curriculum which set out the educational programme and the material resources used to deliver it. The six sites therefore had varying forms and differed in a number of ways which are described more fully in the evaluation report. Details of the two case study sites where group inquiry took place are outlined in chapter three and four.

In this chapter I will describe the group inquiry approach and explain how it was set up as part of a democratic approach to research and evaluation. I will identify three themes that become the framework for analysing the accounts presented in the next two chapters. First, the concept of *participation* will be seen as important for this inquiry. Participation will be understood as based on notions of citizenship and a particular view of 'subjects' who are historically located.

Secondly *ways of knowing* and the kind of claims to knowledge that could be made from this inquiry will be discussed . Since the focus of this inquiry was the educational experiences of two student groups, *experience* provided the basis of their claims to 'know'. By seeking to represent their views I was faced with the problem of 'authorship' and the basis on which my own claim to 'know' could be made. However, seen as a dialogue between myself and the students, the inquiry was able to generate an agreed account of what was discussed. This will raise questions about the nature of consensus and agreement and the conditions under which it was reached which will be discussed in chapter six.

Thirdly I will consider the concept of *emancipation* since through group inquiry, as a form of feminist participatory research, my aim was to produce knowledge for action and empowerment. To be a midwife means to be 'with women' (Kitzenger, 1988; Oakley & Houd, 1990) and midwives often claim to work in the interests of other women and frequently argue for a more 'woman-centred' approach to maternity service provision. They sometimes regard themselves as advocates for the women they care for, and as mediators between the woman and the doctor (who is usually a man). The politics of midwifery and childbirth is about gender politics (Oakley, 1986) and the category of 'midwife' central to the power relations in this public and professional arena. As a woman, nurse and mother I began this project with some concerns about the way in which women are treated as 'users' of contemporary maternity services and the exploitative relations of conventional research methods. My intention therefore was to find a way of doing research **with women** and for women, that would recognise the emancipatory aims of feminist theory and practice. As became clearer during the inquiry, in certain respects my position in the group paralleled the position of the midwife in working with women. For I saw myself as an advocate for the students and a mediator between them and others involved in the evaluation project.

I shared the aims of other researchers to promote a view of knowledge production that was participative, democratic and emancipatory. Therefore I adopt a modernist view here and in chapter six these modernist values will be discussed more fully with reference to the work of Seyla Benhabib who proposes a revised Habermasian discourse model of democracy (Benhabib, 1992). I will argue that this points to a way of rethinking a democratic model of research and evaluation. But first, I intend to set this later discussion in the context of debates within the sociology of knowledge. These debates will be seen as important for elaborating the three themes I have introduced. For, in order to assess this democratic model, and explore the connections between knowledge, power and language, a number of important areas need to be examined. What view of participants was adopted here; what claims to knowledge could be made; how might these be represented; and how might the emancipatory aims of the inquiry be understood?

I shall begin with a discussion of science and ideology which will provide a basis for thinking about competing claims to knowledge and a critique of scientific rationality. In chapter five, this will provide a framework for understanding conflicts between midwives and obstetricians but it also assists in making a case for 'new paradigm' participatory research (Reason, 1988). In the second section I will explore current concerns amongst feminist writers to examine the extent to which a critique of sexist methodologies leads to a feminist standpoint(s). While some argue that a feminist successor science is desirable, or an approach which valorises women as subjects, others suggest that a rejection of scientific rationality and Enlightenment epistemology means feminists must give up modernist aims and embrace postmodern thinking. This discussion of 'subject' positions will be important for understanding the construction of the students' identities as midwives and their role as 'knowing subjects' in this research. This leads me, in the third section to consider the implications of these debates and whether this signals an end to emancipatory projects. The claims made by midwives to work 'with women' will be considered in chapter five and the extent to which group inquiry was emancipatory will be considered in chapter six.

In section four I will examine what is meant by a reflexive approach to sociology and specifically the problems of representation. For, as will become apparent, a reconfiguring of the boundaries between subjects and objects or, to put it another way, a reconception of subject-object relations, points to a need to rethink technologies of representation. Importantly then this led to my particular concerns about how to 'represent' the students' views in chapters three and four, and the ways in which the 'authoring' of those accounts was problematic. Related to this is how diversity and difference within the research group could be represented, whether, a liberal democratic model for this research enables those differences to be articulated. The final section descibes the group inquiry approach and shows how the three themes of participation, ways of knowing and emancipation are central. Group inquiry will be described as taking the form of a dialogue and this will point to the value of a discourse theory of knowledge and a discourse model of legitimacy.

1.0 Science and Ideology

As outlined in chapter one, the development of pre-registration midwifery education may be seen as located historically, in the context of longstanding debates about the role of the midwife in modern society. While midwifery practice was, in pre-modern times, regarded as the domain of the 'wise woman', with the development of scientific knowledge and the use of technology, medical intervention in childbirth became widely accepted, especially amongst the middle classes (Oakley, 1984; Dingwall et al, 1988). With the licensing of midwives, introduction of formal training and the regulation of professional boundaries, divisions between midwives - doctors, and midwives - nurses may be understood, in part, as related to their claims to distinctive knowledge and skills. Against this background, the development and promotion of a programme of education for midwives that has no requirement of a prior nursing qualification and, by its higher level (diploma or degree) seeks to improve the status of midwives, may be seen as contentious.

In order to understand this more fully I shall therefore set out the ways in which claims to knowledge have been legitimated since the Enlightenment. I will show how notions of scientific 'truth' have dominated this period and how this has relevance for understanding the position of midwives generally and student midwives in particular. This is of significance for making sense of their relationship with doctors and nurses and will assist in understanding the ways in which the students construct their professional identities as midwives. I will demonstrate later how, in order for midwives to assert their accounts as legitimate ones, they commonly challenge the dominance of scientific knowledge and its use for the technological control of childbirth. It follows that the knowledge claims of the students, in their accounts of becoming a midwife, depend on a similar critique of scientific knowledge. Moreover the process of inquiring together in order to construct those accounts and the group inquiry method, raises questions about what counts as a legitimate claim to knowledge. The relationships between researchers and researched will also be reconsidered in the light of these critiques, in section 5.0.

1.1 The scientific age

Historical analysis of the development of scientific endeavour identifies *"the rise of the age of science"* from the Renaissance period and is briefly outlined by Gordon (1991). He describes the separation and *demarcation* of science from religious belief and the secularisation of science. While the authority of the Church had until that time been the means by which Truth and falsehood were determined, the claim to scientific knowledge was based on empirical evidence. Early scientists challenged the hierarchical order and authority of the Church and instead argued that Reason and the evidence of the senses was the basis of scientific knowledge and it was accessible to everyone. The enlightened man (sic) was therefore *"free to use what reason they possess, without subservience to authority"* (Gordon, 1991:25), as Gordon says *"it (was) a question of **method**, not of status"* (Gordon, 1991:24). 'Scientific method' was seen as providing the means to understand the natural world but a distinction was made between this and social, political or moral spheres which at that time remained within the authority of the Church. (Though Gordon points out that claims to intellectual freedom were later extended to these other areas of human thought). Yet while these early scientists believed that all men (sic) were rational beings, capable to a greater or lesser extent of using scientific methods, they did not recognise that science itself created a hierarchical order. By making universal claims about scientific truths which they regarded as constant across cultures and independent of the status of the knower, they set scientific knowledge apart from other forms of knowledge and belief.

In his introduction to 'Science, Technology and Society' and a description of a visit to the Science museum, Webster notes that
"the authority of science relies precisely on our perceiving it as something that lies outside society: science is not, in these museums, a contested terrain, an arena where differences of opinion and division appear.....Science deals with 'facts' " (Webster, 1991:1).
It is this presentation of scientific 'facts' in the modern world that has been an *ideological* achievement. Webster draws attention to what was seen as the special character of scientific knowledge and Aronowitz points out that
"in the knowledge hierarchies of postfeudal societies, modern scientific rationality is the privileged discourse, and all others are neglected to the margins" (Aronowitz, 1988:8).

Scientific knowledge made a universal claim to objective truth that obscured the exercise of power in attempts to dominate nature. So that *"by the late nineteenth century, industrial production depended on scientifically based technologies"* and scientific discourse concealed the power relations within the new capitalist order and became hegemonic (Aronowitz, 1988:9).

1.2 The social study of science

As these and other writers have argued, the age of science and triumph of Reason was initially seen as divorced from the social and political relations of the time, yet more recently the intimate relationship between them has been made explicit. Furthermore the production of scientific knowledge itself began to be seen as the result of negotiation and bargaining (within the scientific community), as the product of a social and political consensus (Kuhn,1970; Collins, 1985; Webster, 1991). With this recognition came concern about who controls the scientific enterprise, for in so far as scientists are unable to sustain claims to neutrality or impartiality but rather are seen as subject to political and social influence, both their exploitation and accountability becomes a matter of public interest. If after all science is not *"asocial, non-political, expert and progressive"* (Webster, 1991:1) then in whose interest is work carried out?

While Merton was one of the earliest sociologists interested in the institutions of science, it was not until the 1970's that there was a growing interest in the production of scientific knowledge itself. By problematising the status of scientific knowledge as in some way special and distinctive sociologists working within the social study of science problematise the very idea of 'Science'. According to Woolgar (1988) the demarcation of scientific knowledge from other forms of knowledge rests on essentialist claims about what counts as 'science'. In contrast

"nominalism suggests that features proposed as characteristic of science stem from the definitional practices of the participants (philosophers, historians, and sociologists) themselves" (Woolgar, 1988:21).

Hence in the first instance the social study of 'science' is conceived of as related to an actual object -science; while in the second instance the sociologist studies *"how the term 'science' is attributed to (or withheld from) various practices and claims"* (Woolgar, 1988:21). By adopting the second of these positions Woolgar demonstrates how the distinction between science and society collapses. 'Science' is seen as constituted by social relations and discursive practices.

Woolgar shows how
"the discourse of science is to be understood as a discourse which structures and sustains a particular moral order of relationships between agents of representation, technologies of representation and their represented 'objects'" (Woolgar, 1988:14 emphasis added).
At the centre then of this discourse is a distinction between 'representation' and 'object' and a dualistic world view which is essentialist in character. Science and more specifically notions of 'scientific method' posit a particular relationship between the knower (scientist) and known (natural world) which relies on an ontological view about a pre-existing and independent reality and an epistemological claim to ways of knowing the truth about that reality. The authority of science rests on *an ideology of representation* which defines the relationship in this way and in so doing claims a special status for scientific knowledge as 'factual' and true. Once this is understood, the implications for sociology are far reaching, as Woolgar suggests.

There has been a longstanding debate within the social sciences about the extent to which the methods of the natural sciences could, or indeed should be applied to social research (Winch, 1958). Yet an understanding of the more recent sociology of scientific knowledge which developed a critique of science and relativised knowledge production, points to a reassessment of these issues. While the application of positivist philosophy to social sciences was premised on objectivist claims, this merely obscured the ideology of representation that underlay 'scientific knowledge'. Once the Cartesian dualism which separates the knower from known is undermined, and a constructivist understanding adopted, it becomes pointless to argue that social research should be 'scientific'. As Woolgar says, science itself is exposed as*"non SCIENTIFIC except in so far as it represents itself as such"* (Woolgar, 1988:107). Crucially the active work of the knower as constructor of knowledge may be made visible and the distinction between different forms of knowledge becomes harder to sustain.

1.3 Epistemology- a class analysis

Science, by making universalistic claims for itself, by reporting the 'facts' about the natural world objectively, distinguished itself from ideology. A distinction between science and ideology often invokes an epistemological

claim about the former as true, the latter as false. Commentators such as Barrett (1991)[3] and Aronowitz (1988) note that although Marx and theorists after him recognised that scientific knowledge about nature was *"pressed into service by the bourgeoisie for the purposes of domination,.....the content of its discoveries is not implicated in this relation "* (Aronowitz, 1988:38,40). Such knowledge, mobilised in the development of technologies for capital accumulation, was itself controversially regarded as neutral and impartial, yet *historically contingent. The extent to which Marx* espoused a use of ideology as an epistemological category of falsehood is contentious as Barrett (1991) explains. Rather, a materialist conception of ideology, which is objective in so far as it relates to the material conditions of an historical moment, is more often accepted as an account of Marx's position. It follows from this reading of Marx that knowledge is tied to class position (that being determines consciousness) though again there is much dispute about whether this leads to a relativist or realist epistemology. Epistemological concerns relate to the relationship between *"on the one hand the realm of objects and on the other a realm of knowledge about them"* (Barrett 1991:40), which in turn rests, as already indicated above, on the separation of these two realms. However, according to Barrett

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[3]In her book 'The Politics of Truth' Barrett (1991) examines the concept of ideology. She explores how different readings of work by Marx and subsequent theorists have used (and abused) the concept. According to her analysis it is possible to adopt at least three positions. Ideology as "the mystification of class interests" which relies on a materialist notion of ideology; ideology from an epistemological position which juxtaposes notions of falsehood and truth; and ideology as part of the "expressive totality" of social reality. She explains that the first two of these positions emphasise the illusory aspect of 'ideology', that ideological processes obscure the 'real class interests' or true knowledge. While such a view is defined as a critical or "negative" one it can be regarded as essentialist and positivistic in so far as it presupposes that real interests or true knowledge is *potentially* accessible. In contrast the historicism of Gramsci and Lukacs, is according to Barrett a more "positive" concept of ideology where the ideas of an historical epoch are expressed, though these thinkers retain an analysis of class as central.

Following the more recent work of Foucault, Barrett explores a move away from economic determinism and "the base-superstructure" metaphor or "the economics of untruth" to map out the decline of grand theory and the universal 'subject'. Moving from essentialist notions of an underlying economic and political structure that determines the ideas and beliefs of a class to which ideology may be reduced (a structuralist and mechanistic world view), post-structuralist thinkers such as Foucault are described as creating a space for a multiplicity of 'discourses' or "regimes of truth". While denying the centrality of class position the construction of both an 'object' and a 'subject' as a knowing social being becomes the product of discursive practices. Questions of personal identity are raised and the active construction of 'self' through social interaction is highlighted. In so far then as ideology is tied to notions of class or epistemology post-structuralism may be seen as signifying the end of ideology, though a recognition of the ways in which power is exercised through discursive practices retains important aspects of the concept.

"epistemological relativism does not necessarily entail a denial that there is a real material world. But if our only access to it is via a succession of theories which describe it in mutually exclusive terms, then the concept of an independent reality ceases to have any force or function" (Barrett 1991:39).

The way forward seems unclear, since it is generally agreed that Marx's theory of knowledge was not fully developed, and suggestions have been made to abandon epistemology altogether (Barrett 1991:41). Woolgar's formulation of the ideology of representation above, does precisely this since it problematises the dualistic worldview upon which epistemological theories are premised. Both he and Dant (1991)[4]share with Foucault the idea that both objects and subjects are constructed in discourse, and rather than pursuing divisions between true and false knowledge according to this view, the ideology/knowledge(science) issue is, as Barrett suggests *"cleared away"* (Barrett, 1991:41). Yet Barrett points to the difficulties with attempts to abandon epistemology and argues that to do so is to take up an epistemological position oneself. Positivist philosophy which underpins scientific knowledge leaves out any reference to the status of the knower (as producer) precisely because the objective knowledge produced is said to correspond to an existing and independent object world (objectivism). Furthermore since Reason is seen as the basis of knowledge women are construed as less than rational, deficient in this regard and unscientific.

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[4] In a very clear introduction to his book Dant (1991) outlines a view of a "modern theory of ideology" which retains the illusory or mystifying aspect of the concept. He describes the processes whereby contradictions or discontinuities in the social world are "repaired " or "concealed" so as to appear uncomplicated. These are ideological. According to this view the apparent coherence and reification of social reality (a world of objects) as unproblematic and unquestioned, is a product of these ideological processes. With reference to the work of Mannheim, Dant outlines a programme for the sociology of knowledge which will enable us to uncover these processes through empirical analysis of discourse. By beginning from a position which sees knowledge as a practical achievement of coherence which is accomplished as social action, the contingency of knowledge is made explicit. Following Mannheim all knowledge is regarded as *relational* and contingent on the specific form of social relations at a historical moment. In this way Dant explains that the 'subject' is an historical agent and by locating them within history (time and space?) Mannheim cuts across the subject-object polarity. No absolute or objective knowledge is considered possible, instead accounts are situated historically. While this avoids a form of relativism from which there can be no agreed position for 'knowledge' it does allow for multiple accounts to be produced. A relational approach to knowledge emphasises the situadeness of these accounts within a socio-historical context rather than the relationship between an object and a knowing subject. This, says Dant, opposes epistemology when defined in terms of the latter, but does not abandon it altogether, instead the origins of an idea (knowledge) must be taken as shaping its validity (1991:29). At the same time a deterministic stance is avoided as the subject is seen as having "relative autonomy" in thought, able to exercise some choice between alternative accounts.

Feminist critiques of these contentions offer, in various ways, the chance to reassess the importance of the subject or knower and to re-examine their relationship to (objects of) knowledge. The next section therefore examines feminist critiques of scientific knowledge and the case for feminist epistemologies.

2.0 With Women - feminist epistemologies

Rather than rejecting epistemology altogether some feminist writers propose alternative epistemologies or ways of knowing (see for example Hekman, 1990; Alcoff & Potter, 1993; Stanley & Wise, 1993; Harding, 1986, 1991). These writers begin from a critique of scientific knowledge as androcentric and sexist (bias). They challenge the scientists' universalising claims to objective, value-neutral knowledge and instead draw attention to the ways in which 'science' has perpetrated the ideas of a dominant elite. Knowledge production is understood by these writers as a political process that systematically excludes the voices of women and other oppressed groups. As Hekman points out

"since the Enlightenment, knowledge has been defined in terms of 'man', the subject, and espouses an epistemology that is radically homocentric" (Hekman, 1990:2).

The idea that midwives, as women, are best placed to care for the pregnant and paturient woman, (a view put forward by the Association of Radical Midwives as described in chapter one), may be understood in the light of these feminist critiques. Since the 1980's it has been possible for men to train as midwives, though very few do (Lewis, 1991) but, as will become evident, the position of midwives as <u>women</u> is often regarded as a basis for their ability to deliver appropriate maternity care. Moreover this examination of feminist knowledge will show how debates surounding the role of midwives and obstetricians in the delivery of maternity services are gendered, a view put forward by Ann Oakley (1989, 1992) and elaborated further in chapter five. In addition, this section provides an introduction to feminist theory which informed group inquiry as a feminist participatory approach to research.

2.1 Feminist science?

The work of Sandra Harding is often cited as a useful starting point to explore *The Science Question in Feminism.* She sets out three distinct approaches to the issue:

1. *"Feminist empiricism argues that sexism and androcentrism are social biases correctable by stricter adherence to the existing methodological norms of scientific inquiry"* (Harding, 1986:24).

2. *"Feminist standpoint originates in Hegel's thinking about the relationship between the master and the slave and in the elaborations of this analysis in*

the writings of Marx, Engels and the Hungarian Marixist theorist, G. Lukacs. Briefly, this proposal argues that men's dominating position in social life results in partial and perverse understandings, whereas women's subjugated position provides the possibility of more complete and less perverse understandings.....a morally and scientifically preferable grounding for our interpretations and explanations of nature and social life" (Harding, 1986:26 (see also p148)).

3. *"Feminist postmodernism challenges the assumptions upon which feminist empiricism and the feminist standpoint are based, ...and share(s) a profound scepticism regarding universal (or universalising) claims about the existence, nature and powers of reason, progress, science, language and the 'subject/self'"* (Harding, 1986:27-8).

As Stanley and Wise discuss, the first two of these may be seen as successor sciences (Stanley & Wise, 1990). Feminist empiricists aim to reinforce scientism and by improving scientific methods do better science. They aim to increase the objectivity of scientific knowledge by making explicit the 'context of discovery' and argue that
"a maximally objective science, natural or social, will be one that includes a self-conscious and critical examination of the relationship between the social experiences of its creators and the kinds of cognitive structures favoured in its inquiry" (Harding, 1986:250).

According to Stanley and Wise, feminist standpoint epistemology goes further by proposing that the oppressed position of women enables them to be better placed, both morally and politically, to do science and therefore knowledge is less distorted.[5] While Stanley and Wise suggest that this is a more radical formulation both may be seen as successor sciences since they retain aspirations to be objective and *"accept the existence of 'true reality'"*(Stanley & Wise, 1990:27). Yet Stanley & Wise then go on to problematise the truth claims of feminist standpoint as a successor science because it allows the possibility of other standpoints while claiming not be relativist and this they say reveals contradictory aspects of these ideas. According to them Harding does not satisfactorily account for the pluralism

[5] See Bat-Ami Bar On Marginality and Epistemic Privilege in Alcoff & Potter (eds) (1993). She says that as marginal groups Black women are unable to sustain their version of events in the face of accounts by dominant groups.

within feminism or follow through the consequences of the standpoint position. So I shall examine these "tensions" in more detail.

2.3 Subject positions

In my view to attribute to Harding the idea that there is a single feminist standpoint is unjustified. She clearly refers to standpoint epistemologies and discusses *"fractured identities"*. In a recent paper Harding says *"the subjects/agents of knowledge for feminist standpoint theory are multiple, heterogeneous, and contradictory or incoherent, not unitary, homogenous and coherent as they are for empiricist epistemology. Feminist knowledge has started off from women's lives, but it has started off from many different women's lives, there is no typical or essential women's life from which feminisms start their thought"* (Harding, 1993:65).

She contrasts the empiricists' reformism with standpoint theory along four dimensions all of which relate to how the subject is conceived.

Empiricist subject

1. disembodied, invisible and ahistorical
2. a clear distinction between subject and object as objects pre-exist
3. individualistic - individuals produce knowledge
4. homogenous and unitary

Standpoint subjects

1. embodied and visible, historically situated
2. subject and object both culturally constituted
3. communities produce knowledge
4. heterogenous and multiple

2.4 A reconception of 'objectivity'

Now while Stanley & Wise suggest that *"once one 'feminist standpoint' is admitted to exist, then other and alternative standpoints become possible, and this in turn problematises the truth-claims of feminist standpoint as a 'successor science'"* (Stanley & Wise, 1990:27),

I am not sure that I can agree. If by their own admission it qualifies as a successor science on the basis that it accepts the premises of 'scientific endeavours' and accepts the existence of 'true reality', the possibility of multiple standpoints does not, according to Hardings' argument, jeopardise this. For she claims that what is needed is a reconception of objectivity

"the problem with the conventional conception of objectivity is not that it is too rigorous or too objectifying, as some have argued, but that it is not ***rigorous or objectifyng enough*** *"* (Harding, 1993:50 emphasis added). Her proposal is that by a systematic and reflexive assessment of the values of the subject, objectivity may be increased; and the recognition of other standpoints serves to provide the starting point for the production of knowledge precisely because it draws attention to the value-laden position of that subject. That is not to say that a white, middle class woman researcher speaks from a position of authority or value-neutrality but that she explicitly acknowledges her position and the position of others as a starting point for achieving greater objectivity. As she goes on to say, feminist standpoint

"argues against the idea that all social situations provide equally useful resources for learning about the world and against the idea that they all set equally strong limits on knowledge" (Harding, 1993:61).

She is therefore able to accept what she calls *sociological relativism* while at the same time rejecting *epistemological relativism* (Harding, 1993:61). In so doing

"standpoint epistemology sets the relationship between knowledge and politics at the centre of its account in the sense that it tries to provide causal accounts -to explain the effects that different kinds of politics have on the production of knowledge" (Harding, 1993:55).

Reflexivity then, according to Harding, becomes a resource for objectivity and the subjects of knowledge are put at the centre of the process *"on the same critical, causal plane as the objects of knowledge"* (Harding, 1993:69). So a realist ontology is maintained and epistemological relativism avoided but both subject and object are seen as culturally constituted for *"whatever kind of social forces shape the subjects are also thereby shaping their objects of knowledge"* (Harding, 1993:64).

What is indicated here is the problem of essentialism described by Woolgar above. Any suggestion that feminist epistemologies are (or are not) successor sciences, clings to essentialist ideas about what counts as 'science' in the first place. Is it reliant on a realist ontology? objectivism? 'scientific method'? a universal subject? universalising claims to truth? As is becoming apparent, these are not always helpful questions since they often collapse ontology, epistemology and methodology while at the same time leave space for a redefinition of central concepts such as 'objectivity'. Paradoxically, to criticise 'science' is to define it (Capra, 1992). However

what is of more concern here is the ways in which subjects may be reconceptualised and Stanley & Wise provide a further suggestion.

In an elaboration of feminist standpoint theory they propose that the notion of *"fractured foundationalism"* is helpful in that it *"speaks to the existence of different, overlapping but not coterminous material realities"* (Stanley & Wise, 1990:41) which overcomes a dichotomy between foundationalism and relativism and links the ideological and material together. For them it seems the realist notion of a single reality seen from different standpoints is unsatisfactory (their criticism of Harding) and instead they seek to bring together the ontological and epistemological basis of feminist knowledge. Their view is a useful one for it attempts to ground knowledge in the divergent experiences of women and blurs the boundaries between subject and object, but their reading of Harding's position is, as I have indicated, in some respects hard to justify. By rejecting a dichotomous and a dualistic world view Stanley & Wise and others such as Hekman (1990) engage with the postmodern critique of science and it is to this that the next section now turns in recognition that there are both common and divergent interests between postmodernists and feminists.

3.0 Celebrating difference -'Other others'

So far I have referred to feminist empiricist and standpoint epistemologies and increasing concerns within feminist thought to recognise that 'woman' is itself not a unitary category, that diverse experiences characterise what being a woman means. Consequently rather than accepting essentialist (or foundationalist) ideas of what counts as 'feminist' there has been a celebration of differences within feminism that actively creates space for a range of feminisms - for example, lesbian women, Black women, working class women. The dangers of asserting a feminist perspective of white, middle class, heterosexual women as representing these differences have been recognised. In a brief introduction to postmodern feminism, Tong suggests that

"In our desire to achieve unity, we have excluded, ostracised and alienated so-called, abnormal, deviant, and marginal people. As a result of this policy of exclusion, we have impoverished the human community. We have, it seems, very little to lose and much to gain by joining a variety of postmodern feminists in their celebration of multiplicity. For even if we cannot all be One, we can all be Many. There may yet be a way to achieve unity in diversity " (Tong, 1992:233).

Indeed she says *"attention to difference is precisely what will help women achieve unity"* (Tong, 1992:237). So paradoxically the notion of unity which may be viewed in some cases as exclusionary is seen here to be inclusive and encompassing diversity.

3.1 Unity in diversity?

What is at issue is how a philosophical reconception of the category 'Woman' as subject impacts on feminist political strategy. For as we shall see a central criticism of postmodern writers is that the deconstruction of a universal (male) subject undermines the basis of both class based politics (ie. Marxism) and feminism, leaving a political void, or worse maintaining the status quo. As Richter explains

"Women's relation to postmodernism is thus ambivalent. While feminism needs deconstructionist strategies to dissolve male master-narratives, at the same time it must remain aware of the adverse effects of these strategies on feminist politics. For political reasons an oppositional solidarity between women grounded in historical and present experiences is necessary.....The necessity of solidarity for strategical reasons raises, however, another dilemma for women who accept the validity of

postmodernism's call for acknowledging difference ....." (Richter, 1991:130).

She argues that while presently equality is regarded as co-terminous with sameness, feminists

"have to criticise concepts of equality and justice which imply sameness, while relying on ones that rest on recognizing differences - differences that confound, disrupt and render ambiguous the meaning of any fixed binary opposition" (Richter, 1991:131).

It is the apparent fixedness of categories such as women/men that is the focus of attention for postmodernists and is at the centre of a reassessment of identity politics.

3.2 Identity politics

Identity politics rests on a personalising of politics and identification or sense of belonging to a group. Hall explains how as a new social movement of the 1960's, *"the great watershed of late modernity"* (Hall 1992:290), feminists appealed to women to challenge their social position and the formation of sexual and gendered identities. In a search for unity and solidarity feminists emphasised this identification as part of an oppositional strategy to overturn patriarchy and capitalism. However as Ferguson (1993) explains such a strategy depends on groups policing their boundaries, on asserting membership of them and claiming an identity. In this conception of the feminist subject, identity became a fixed and unifying concept. Shared experience of oppression was the basis of this sisterhood but the consequences of this was to exclude and silence those whose experiences were in some ways divergent (eg. Lesbian women). Identity politics then, may be seen as located historically within the modern world where the ascription of male and female roles has been characteristic of industrial society (Beck, 1992; Hall, 1992). The deconstruction of the subject by postmodern writers and more recent feminist writing signals a challenge to this formulation of feminist projects and will assist in understanding the politics of knowledge production.These concerns are at the centre of debate between postmodernism and feminism as we shall see.

3.3 A dualistic world view

In the opening chapter of her book Susan Hekman describes the relationship between feminism and postmodernism as *"uneasy"* and *"anomalous"*. Yet since both

"feminism and postmodernism challenge the epistemological foundations of western thought and argue that the epistemology that is definitive of Enlightenment humanism, if not all western philosophy, is fundamentally misconceived", (Hekman, 1990:1);
she argues that there is an important convergence between them . However she suggests that contradictorily, contemporary feminism clings to values that are modernist. According to her, feminist projects must be explicit in aligning with modernism or postmodernism and in her view, only by a wholehearted rejection of Enlightenment epistemology may these projects be advanced.
"The attempt to preserve the 'good' aspects of modernity, or even to privilege the feminine over the masculine, cannot escape from the inherent sexism of Enlightenment epistemology" (Hekman,1990:8).
She suggests that feminism may provide a corrective to postmodernism by defining those dualisms that are central to Enlightenment epistemology as gendered, but postmodernism
"reveals the futility of the attempt to define an essential female nature or to replace the masculinist epistemology with a feminist epistemology" (Hekman,1990:8).

So, according to this view, attempts by feminists to develop successor sciences are misguided, and clinging to notions of objectivity or truer knowledge is contradictory. For though writers such as Harding begin from a critique of scientific rationality and she
"claims to be rejecting the dichotomies of Enlightenment thought, she is unable to conceptualise knowledge in terms that displace this dichotomy" (Hekman, 1990:134).
Hekman suggests that instead these dichotomies are reconstituted by Harding's assessment of postmodernism as relativistic, in opposition to absolutism, and a continuing adherence to notions of a single, true feminist story of reality told from multiple perspectives of women. This dichotomy then, may itself be seen as historically specific and tied to modernity[6]. Hekman's assessment of Harding's position might also be pertinent to a discussion of Stanley & Wise's view which they elaborate in *Breaking Out Again* (1993).

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[6] Thanks to Lisa Adkins for drawing my attention to this.

3.4 Materialism revisited

Stanley & Wise are forceful in their criticism of recent postmodernist writing and object strongly to what they regard as *"the colonising activities of postmodernist intellectual imperialism"* (1993:190). While claiming certain *" ideas as the common property of a number of divergent intellectual traditions "* (an interesting reference to tradition) they argue for *"a materialistic, but not a marxist, theory of knowledge, one irrevocably rooted in women's concrete and diverse practical and everyday experiences of oppressions"* [and insist]*"that these analytic knowledges are reflexive, indexical and local: they are epistemologically tied to their context of production and are ontologically grounded "* (Stanley & Wise, 1993: 191). This they call *feminist fractured foundationalist epistemology* and emphasise that *"there is nothing separate from social life and experience, nor which exists outside it "* (Stanley & Wise, 1993:192) - <u>being</u> is foundational though not reified as beyond culture but rather culturally specified. They are critical of the *"linguistic turn of post-structuralism"* in the work of, for example Irigary and say it *" is not a sufficient basis for a feminist praxis".*

Instead, in agreement with Irigary, they say *"that women's bodies and the (constructions of) difference of these from men's are central to the category 'Women' and its sexually politically subordinate status"* [and they argue that] *"to claim an essence for the category 'Women' continues to be a highly successful political strategy..."* (Stanley & Wise, 1993:199).
It follows therefore that Stanley & Wise reject the idea that deconstructing binary categories linguistically is adequate as a political strategy but instead they say change at the level of experience, and of practice is needed. In seeking to retain what they recognise as a binary distinction between Women and Men as categories, Stanley & Wise believe that this is necessary for *"a distinctively feminist philosophy and praxis "* to emerge rather than *"an apparently ungendered deconstructionist position"* (Stanley & Wise, 1993).

3.5 Collectivism or individualism?

Critics might suggest that Stanley & Wise's position is an essentialist one but they refute such criticisms, saying that charges of essentialism are themselves essentialist for they assume a unitary, coherent and fixed meaning to the term 'essentialism' (Stanley & Wise, 1993:209). Indeed according to their analysis, and with reference to Derrida's work, constructionism and deconstructionism are premised on

"essentialist elements at its foundation, for it proposes that there are 'real' social objects outside or beneath the social construction of these" (Stanley & Wise,1993:219).

In contrast, their conception of Women as a category includes the experiences of different women and is not therefore fixed or unitary but fractured. Although the constitution of Woman as Other is a product of western thought, for them difference is fundamental to feminism which must necessarily revolve around fragmentations and differences of thought and practice (Stanley & Wise,1993). Unlike Hekman who ties the categorisation of women/men to essentialism, for Stanley & Wise this binary opposition is politically necessary. While Hekman might argue that this will lead to a recapturing of feminist projects, for them the recognition of multiple ontologies and epistemologies within feminism enables the projects for feminists to be more clearly specified. Yet in reasserting and indeed celebrating the difference between Women and Men, Stanley & Wise warn against the dangers of individualism. For they see a creeping individualism in postmodernist writings which fragments and isolates the individual and ignores that which is shared (Stanley & Wise, 1993).

Finally, rather than proposing that either all epistemologies are equal or that feminist ones should be privileged Stanley & Wise suggest that there are acceptable political and moral grounds for preferring one epistemology over another and the grounds for preference are ontological - *"that it better fits with a proponent's experience of living or being or understanding"* (Stanley & Wise, 1993:228). The material grounding (foundationalism) of their epistemology therefore locates the producer of knowledge contextually and historically and, while valorising the experiences of other, Others provides a base from which judgements may be made about knowledge claims. For them this philosophy can be sustained and provides a political strategy for *'Breaking out'.*

In summary then, Stanley & Wise embrace and celebrate the differences *between* Women and Men , between women and between men, but they do not seek to replace the hegemony of male dominated science with a new orthodoxy of feminist thought dominated by white, middle class academic women. Instead by fracturing the category Women they invite us to see knowledge as *"situated, specific and local to the conditions of its production and thus to the social location and being of its producers"* (Stanley & Wise, 1993:228). Yet for others such as Hekman, a critique of the dualism of

Cartesian thought necessarily implies a rejection of a distinctively feminist epistemology and a rational subject. For, according to her and writers such as Derrida

"Binary oppostions that are at the root of conceptuality itself are erupted by the supplement. What Derrida has accomplished with his notion of the supplement is even more radical than disrupting these foundational binary oppositions. He goes further to reveal that the binary oppositions of western thought are not, in fact, opposites at all. The oppositions he analyses reveal themselves not as polarities but as two confused elements that inhabit each other . In his notion of the supplement Derrida quite literally deconstructs the basis of western logic. As one of his critics has noted, supplementarity is a dangerous concept because it reveals a deep structural contradiction within western epistemology" (Hekman, 1990:172).

Difference then, following this line of thought, is conceived of in terms of the elements of a whole and differentiating between categories such as male/female, Women/Men is rendered meaningless and politically counter productive[7]. So Hekman argues that to reject rationalism in favour of the irrational (female) or to seek a feminist epistemology to replace the masculinist one is to *"reify the Enlightenment epistemology that it seeks to overcome"* (Hekman, 1990:7).

3.6 Fractured foundationalism

While Stanley & Wise set out not to advance a new orthodoxy they are explicit in their intention to assert a feminist epistemology and in regarding **being** as the foundation of knowledge. At the same time they see the knowledge producer as **becoming**, in a state of change and instability. This does not preclude the creative process of representing to each other our worlds but rather grounds that representational effort in a socio-historical and material world **for practical purposes.** The notion of fractured identities dissolves a fixed unitary self but does not produce chaos and incoherence, it emphasises the agency of individuals as members of different collectivities enabled in the creative and constructive process of telling stories about themselves and representing their worlds to each other. It also usefully draws attention to *"the body not merely as a linguistic creation but as also having a physical, material and consequential reality"* (Stanley & Wise, 1993:197). Their criticism of postmodernists is based on an apparent ungroundedness of linguistic analysis where politics is reduced

[7] See notion of complementarity in Capra 1992.

to a series of language games, but the extent to which this is justifiable is itself contentious.

3.7 The discursively constructed 'subject'

The foundationalism of Stanley & Wise has been critised as prioritising *experience* [8]. Scott sees *"Experience"* as problematic for according to her *"making visible the experience of a different group exposes the existence of repressive mechanisms, but not their inner workings or logics; we know difference exists, but we don't understand it as constituted relationally. For that we need to attend to the historical processes that, through discourse, position subjects and produce their experiences. It is not individuals who have experience, but subjects who are constituted through experience. Experience in this definition then becomes not the origin of our explanation, not the authoritative (because seen or felt) evidence that grounds what is known, but rather that which we seek to explain, that about which knowledge is produced. To think about experience in this way is to historicize it as well as to historicize the identities it produces"* (Scott, 1992:26).

In Hennessey's work the materiality of discourse is highlighted (Hennessey, 1993). She explores the tension between the experiential self, and the discursively constructed subject, between the nondiscursive (women's lives) and the discursive (feminist critique) . She points out that emphasis on the former is empiricist and returns to questions of identity politics. Instead she sees discourse as ideology and ideology critique as social practice which, rather than depending on belonging to a particular group (women),

"speaks from a counter-hegemonic collective subject" [and] *"shifts concern from the grounds for knowledge to the effects of knowledge as always invested ways of making sense of the world"* (Hennessey, 1993:96/7).

In so doing the possibility of common ground between feminists and *"other counter-hegemonic standpoints"* may be realised and challenge the hegemony of western philosophical thought and political systems. This view resonates with what Ferguson calls *"mobile subjectivies"* where coalition politics may be understood as the coming together of persons who *"can feel empathy with many different perspectives but find themselves fully at home in none"* (Ferguson, 1993:178). Subjectivity is seen as mobile, *"temporal, moving across and along axes of power (which are*

[8] A criticism they refute see Stanley & Wise 1993.

themselves in motion) without fully residing in them" (Ferguson, 1993:154).

For both Hennessey and Ferguson, then, celebration of difference is politically effective and shifts attention away from "Who am I?" to "What can we do?", it keeps the political agenda alive and ever changing while at the same time provides a platform from which to speak. Furthermore according to Hennessey (and Scott), the materiality of discourse and an understanding of how the writing of history is itself constructing a narrative of the feminist subject at a given historical moment, reconciles the aims of feminism with a postmodern theory of discourse.

3.8 Mobile subjectivities

What is apparent from this discussion is that while the idea of a universal subject has come under attack from both feminists and postmodernists, there is a continuing debate between them about the implications of what this might mean. Some feminists, such as Harding, have argued for a revised approach where feminist standpoint(s) provide a morally and objectively more acceptable view of reality. Others, such as Stanley & Wise, while rejecting claims to objectivity or scientificity, have argued for *fractured foundationalism* which emphasises the importance of the body as a site of experience and *being* as the foundation of knowledge. Their view was contrasted with a postmodern critique by Hennessey and Ferguson who focus attention on the discursive formation of experience and being and the materiality of discourse, while Scott's analysis situates identities historically.

In my view there are points of agreement between each of these positions as well as areas of divergence but what has been central to conflicts between them is a debate about political strategy based on contrasting views of the relationship between 'individuals' and 'society'. How we conceive of relationships between individuals or 'subjects' in the private or personal sphere is closely tied to conceptions of institutional forms of 'society' within which public debate takes place. This in turn relates to a view of public space where participation may be seen as contingent on a pre-defined or fixed identity (identity politics), or where participation is seen as part of *a reflexive project of self* whereby identities are constructed and articulated discursively within specific institutional contexts. This latter view is advocated by Giddens (1991) in his discussion of life politics . According

to him, a politics of choice follows from a level of emancipation that is present in high modernity where the self is relatively autonomous and the reflexive project of self is tied to global and local environments (see chapter 7 in Giddens 1991). For him, this is the result of the breaking down of old identities of class, and gender as increasingly diverse forms of identification have become important. Moreover according to Beck (1992) a process of "individualization" enables new coalitions to be formed. Old alliances (categorisations) are then seen as a less effective basis for political action and instead diversity may be celebrated.

From this discussion of the ascendancy of scientific rationality, recent studies in the sociology of science, feminist critiques of science and mobile subjectivities; what begins to come into focus is a view of how the identities of midwives are constructed as distinct from nurses and doctors, and how this is contingent on claims to knowledge and skills that are **different**. The belief that midwives are different is a critical one. Moreover, how we conceive of the student midwives as 'knowing subjects' will depend on an understanding of how subject positions are constituted, and how subject-object relations are mediated by language. The problems of representation may now be considered in more detail for, the ways in which the student midwives talked, and wrote about their experiences, and the work of producing both an evaluation report and this thesis raises issues about how those subject-object relations could be represented. What stories or accounts of 'experiences of becoming a midwife' could be told and how could diversity between students be represented? How were knowledge and power related in this research? The next section provides a more detailed discussion of representation and the concept of reflexivity.

4.0 A Reflexive Project

According to Ashmore (1987) there are three ways of thinking about *reflexivity* - R-reference, R-awareness and R-circularity. The first of these reflexivity as self-reference, refers to the self-referential character of social science which *'can be considered an implicitly self-referential discourse in that if it is about humans and their social arrangements then it is (also) about those humans in those social arrangements who are responsible for the production of social science"* (Ashmore, 1987:32). Reflexivity as self-awareness, the second of these, is seen as *"benign introspection"* or reflection (see Woolgar, 1984; 1988:22) which both Ashmore and Woolgar say is unproblematic in that it *"merely"* exhorts us *"to think more deeply about what we do"* (Ashmore, 1987:32). While the third way of thinking about reflexivity which Ashmore calls R-circularity refers to *"the essential reflexivity of accounts ... taken to reside in the constitutive nature of accounts and reality"* (Ashmore, 1987:32); what Woolgar calls *"constitutive reflexivity"* (Woolgar, 1988). In this inquiry, for me, the implications of thinking about reflexivity in these ways, (which Ashmore sees as neither comprehensive or mutually exclusive) were threefold.

First, given the above discussion of scientific rationality and debates between feminists and postmodernists I needed to rethink the social relations that characterise social science knowledge production. How after all are subject-object relations defined in group inquiry, what view of the students and my self as subjects or objects was adopted? In order to assess and evaluate my position it seemed that some form of introspection or reflection on the research process would be useful by enabling me to gain insight into the inquiry process itself. Finally the notion of constitutive or circular reflexivity problematised the ways in which I could represent the views of the students in the group and indeed the authoring of the research account. For in what sense would the process of writing (re-presenting) the research transform or constitute the 'reality' of what it was like to be a student on these pre-registration midwifery courses?

4.1 A crisis of representation

The critique of Western philosophy referred to above and challenges to a dualistic world view, are often understood as signalling a "crisis of representation". This may be seen as a feature of the post-modern condition as Pels & Nencel explain in their account of the authority and critique in social science and contemporary 'crisis' in anthropology (1991). For, if as

has already been suggested 'scientific' discourse is *"a moral order of relationships between agents of representation, technologies of representation and their represented 'objects'* " (Woolgar op cit), then by undermining the claims of scientists to provide authoritative accounts (representations of an object world), by extension, the authority of agents of representations (authors) may be called into question and realist versions of 'truth' dismantled (Lawson, 1989). The stories we tell about reality can no longer be seen as *corresponding* to an independent pre-existing object world, but rather the meaning of truth, like other meanings, may be seen as a function of language as Wittgenstein and more recently Derrida have argued (Lawson, 1989).

This linguistic turn in post-modern theory was strongly criticised by Stanley & Wise and many others. For it is argued, according to such a relativist view there is no way of arbitrating between accounts, by standing outside either history or language and so the authority of all of them may be called into question, (Lawson, 1989). As we have seen this is regarded as politically vacuous and/or inherently conservative However, by rejecting (as Stanley &Wise do), the grand theories or meta-narratives of modernism which exclude the voices of oppressed people, it follows that enabling alternative accounts to be heard is desirable. But how can these diverse accounts be heard and does creating space for multiple accounts necessarily imply that all accounts are equal? Of course it does not. Both Harding and Stanley & Wise pointed to ways in which the claims of different feminist accounts might be assessed, so the sound of many voices speaking need not lead to anarchy or conservatism. For Harding, there was a distinction between sociological relativism and epistemological relativism and according to Stanley & Wise judgements between accounts could be made on moral and political grounds. In practice, we all necessarily act as if certain accounts have more validity than others in order to proceed about our daily lives and to take up the struggle against oppression. However, to acknowledge the possibilities of alternative accounts and to question the certainties of the modernist 'scientific' project does present a threat to the academy and the authority of the (male) expert, scientist or sociologist (Atkinson 1992) and this was of concern to me in conducting and writing about this research.

4.2 Literary devices for deconstruction

In discussing the role of the agent of representation Woolgar pointed out that sociologists of scientific knowledge though critical of scientists, have reproduced the same representational practices in their own writing. Taken seriously, the ideology of representation must be breached by the critic to disrupt *"the supposed neutrality and authority of the agent"* and to problematise the relationship between the author and text (Woolgar, 1989). Rather than a conventional, univocal textual form he demonstrates the use of a second voice as a 'new literary form' (see also Ashmore, 1989; Cooper, 1992). This serves to highlight the constructedness of the text by an author and to interrogate the self in representation -

"you could construe the interrogation of self as just the latest step in a long historical progression: self was radically displaced by the Copernican revolution, and took refuge in science; then self was displaced from science by the relativised sociology of scientific knowledge and took refuge in the Author, the unreflexive social scientist. With the exploration of new literary forms, the spotlight is turned on Author in an effort to chase out self again" (Woolgar, 1989:142).

Woolgar's purpose here is to suggest that the use of such literary devices are a means of deconstructing the ideology of representation, to show that the subject (self) and object (other) are not distinct and separate spheres but are bound together in the text. In this way the conventional or realist accounts which usually take the form of a monologue are exposed as textual devices for constructing the author as knower and the other as known, for creating a distance between them. The crisis of representation then is also a crisis of 'self' as subject. In contrast, a multivocal approach fragments the self and sets up a dialogue which creates a space for alternative accounts to be given. The use of irony effectively blurs the boundaries between subject and object. It may also blur the distinction between 'fact' and 'fiction' since by problematising the notion of 'facts', 'telling stories' may be seen as having a legitimate purpose (see for example Mulkay, 1985).

4.3 Story telling

In Atkinson's discussion of ethnographic texts as story telling (narrative) and the 'poetics' of ethnography (Atkinson, 1990; 1992) producing knowledge, sense making, is regarded as a *creative* process and doing ethnographic social research is a textual accomplishment. Increasing emphasis has been placed on the *writing* of research accounts and the textual devices used to construct the research 'field' or object and its distance from

the researcher as knower/subject. Within recent ethnographic and anthropological work the ethical or moral dilemmas and political consequences of the writer constructing their informants as 'other' have been given attention, particularly by feminist writers. Increasingly, the knowledge produced is framed instead as the product of a dialogue, co-produced by a researcher who explicitly aims to put the research participants at the centre of the research and to give voice to them.[9] Even more conventional 'scientific' reports (in this example quantitative analyses) are seen to have textually disembodied knowledge by stripping from it the researcher's experience (Aldridge, 1993). Aldridge, in recognising the rhetorical function of these textual devices treats the texts themselves of analytical interest as a way of examining their epistemological claims. So the literary techniques used by social researchers have been reflexively highlighted both as a way of providing a critique of the local conditions of knowledge production and as part of a more wide ranging critique of dominant 'rationalist, scientific' projects. Consequentially, this crisis of the self has been significant in the resurgent interest in auto/biography.

4.4 Research as auto/biography

Sociological interest in auto/biography is currently much in evidence as indicated by the 1993 BSA Sociology edition devoted entirely to this topic (see for example Cotterill & Letherby 1993). It has been particularly important to feminist researchers who according to Stanley in writing their research accounts *"should locate the feminist researcher firmly within the activities of her research, as an essential feature of what is 'feminist' about it"* (Stanley, 1990:12). It is also important for social constructivists who emphasise that our own research activities tell a story about ourselves, through the stories of others (Steier, 1991), and who acknowledge the intimate connection between researcher and researched as "constitutive reflexivity" (Woolgar, 1988:22). Social research is commonly about the lives of others and ourselves, and therefore is auto/biographical. By focusing on the personal, the individual as a *social* being may be re-integrated into social theory (Evans, 1993). While this is not to suggest the acceptance of a creeping individualism Evans says it is consistent with the pluralism of the 1990's and contemporary social and political theory.

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[9] Researchers doing critical and participatory ethnography go beyond cultural descriptions to adopt an emancipatory and action oriented agenda in order to promote the concerns and interests of those they research (Thomas, 1993).

Furthermore, autobiographies and biographies are not exclusive genres, since in writing about ones own 'life' (auto) inevitably the lives of 'others' are intertwined (biographies). Conversely, writing the life of 'an-other' is to write about one's own life, the life of the researcher/ writer/biographer/author.The *"intellectual biography"* of the writer is directly relevant to, and inherent within the text (Stanley, 1993).

The importance of narrative in constructing research accounts is acknowleged in this thesis. As a reflexive project I wanted to examine ways in which the story of the student midwives was tied up with my own story. I faced a number of 'problems' that will be worked out over the next few chapters but here I have pointed to two major issues. First if by the very process of writing a research account a researcher silences the voices of (other) others, how might this process become more 'democratic'? How could I give voice to the student midwives who agreed to take part in this research, and how might their voices be heard in the report/thesis? Secondly how might an account(s) of the conditions of the production of the research be included, in order to reflexively attend to the situation of the inquiry groups? In writing chapters three and four I will attempt, in collaboration with the students, to explore these issues. In chapters five and six I will revisit the issues in order to give my assessment of what was accomplished.Yet in my discussion so far there has been an important omission for in the process of writing, a reader is configured. You the reader will have a key role to play . For the writing of a research account is not straightforwardly the end stage of a lengthy research process. Rather it is a beginning. You, the reader are asked to judge how successfully these issues are explored, whether a resolution is achieved or if indeed such a resolution is possible. What other stories might have been told?

In the final section of this chapter I begin to tell a story about this particular inquiry, and how a democratic model of research and evaluation was adopted in order to give voice to those involved in pre-registration midwifery education. This will enable me to explore further the relationship between knowledge and power, democracy and truth.

5.0 A Democratic Model of Research and Evaluation

In this final section I will describe how *group inquiry* was set up as part of the evaluation project and identify three themes that will become the framework for analysing the accounts presented in the next two chapters. First the concept of *participation* is seen to be important for it implies a view of a subject, actively taking part in the research and is later related to participation in midwifery practice. Secondly, in this inquiry, the experiences of the students on two pre-registration midwifery programmes were regarded as the basis of their claims to knowledge which raised questions about *ways of knowing* and the extent to which feminist epistemologies were accepted. In chapter five it will also be seen as important for understanding the debates between midwives, doctors and nurses. While a third theme relates to the concept of *emancipation.* It will be identified as a feature of the feminist participatory approach adopted in an effort to do research that was with, and for, women. Later I will explore how far this underpinned the students' views of midwives as co-workers 'with women'.

5.1 Group inquiry - two case studies

The use of a case study approach in educational evaluation is not new. It is commonly used as a form of *"naturalistic inquiry"* (Guba & Lincoln 1989) and is seen as providing rich, detailed, descriptive data together with contextual information (Simons 1977). It is also regarded as more 'democratic' in that it facilitates dialogue between 'stakeholders' and evaluators (Macdonald & Walker 1977). Indeed it was hoped that close contact and in-depth fieldwork in the six case study sites would enable the evaluators to gain insight and understanding into the concerns and issues of those involved in pre-registration midwifery programmes. *Group inquiry,* as a form of feminist participatory research, was consistent with the values of a democratic approach to evaluation and took place at two of the case study sites. By highlighting the themes of participation, ways of knowing and emancipation I will be able to re-examine the liberalist assumptions that underpinned the evaluation approach and also consider the implications of a democratic view of knowledge production which informed this inquiry.

5.2 Participation

First the idea of *participation* is at the centre of participatory research and this raises questions about who participates and what are the conditions for it? As already indicated the evaluation sought to promote democratic accountability by representing the views of stakeholders in midwifery education. As part of the evaluation strategy and the case study method used at two of the case sites, two inquiry groups were 'set up' to explore the students' views. [10] Access was agreed with the midwife teachers and education managers at each site. My intention was to adopt a participatory approach to the inquiry that would give **voice** to two of the least powerful groups - the student midwives. This would be research with and for them rather than on them and drew on earlier work by Reason (1988), Maguire (1987) and others (Reason & Rowan, 1981). Such an approach begins from a critique of 'orthodox' research which produces 'alienated knowledge', that is knowledge, which John Heron says *"excludes from the field of research just that aspect of being -self determination - which particularly characterises the subjects as persons"* (Reason, 1988:4). Proponents of participatory research suggest that by sharing of power at each stage of the research process participants are empowered to produce knowledge that is of value to them and has an emancipatory potential.

Participation is a central concept in group inquiry. It is premised on ideas of citizenship[11] and each participant in the research being actively involved. This is summed up by the notion of participants as *co-researchers*, jointly contributing to the research. Through dialogue and discussion it is expected that members of the group share in setting the research agenda, asking research questions, producing data or record keeping, analysing and writing it up. While the idea of a full partnership or *"authentic collaboration"* rests on everyone contributing, it is not necessarily the case that each person will contribute in the same way, or to all of these activities, but the principle of collaboration and sharing tasks remains central (Heron, 1981; Reason, 1988). At the outset, Reason suggests that skills and different roles within the group need to be identified and then re-negotiated if necessary, as the inquiry progresses (Reason, 1988). While one researcher may initiate the inquiry, the basis for collaboration must be agreed and questions asked

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10 Reason says inquiry groups can not be set up but *emerge* (Reason 1988)

11 For a recent discussion of the concept and gendering of 'citizenship' see Walby 1994.

about *"who is the research really for?"* and whether there is the possibility of *"a genuine co-operative endeavour"* (Reason, 1988:20). At the stage of contracting, or agreeing access for the inquiry, Reason says

"the important point here is to be sure that the project the initiator wants to do is one that makes sense to potential group members; and to be careful that any differences in power or status deriving from organisational or social position do not make it impossible to negotiate an open contract" (Reason, 1988:21).

He points out that there is also an important paradox underlying this collaboration, that what he calls co-operative inquiry (but I prefer to call group inquiry) *"implies equality and a democratic process in which we can all engage; yet it is not a causal and unstructured process"* (Reason, 1988:19). Moreover it is

"likely that the group will need some democratic leadership which is both facilitative and educative -facilitative in the sense of offering structures and processes which may help the group in its work; educative in teaching members about effective group working" (Reason, 1988:27).

Reason draws on literature referring to theories of group development to explicate the ways in which groups might work together but my interest is in focusing attention here on the dialogical (or discursive) features of group inquiry.

Participatory research is sometimes called *dialogical inquiry* (Randall & Southgate, 1981 in Reason & Rowan 1981) and, as already indicated, participation may be understood in terms of the capacity of individuals to take part in a dialogue and thereby to give voice to participants. One of the aims of group inquiry was precisely this - to give voice to the student midwives who took part, to find ways that would enable them to set the research agenda, decide what were important questions, express their views and involve them as far as possible in the interpretation and analysis of the inquiry, even perhaps the presentation of an inquiry report. The conditions under which such a dialogue might take place are important then for facilitating participation and these will be discussed more fully in chapter five. Following negotiations with the senior education and service managers students on the two diploma courses were invited to attend a meeting to discuss their participation in group inquiry (separate meetings were held at each site - see chapters three and four). The idea of inquiring together as 'co-researchers' and sharing responsibility for setting the research agenda, generating questions, writing and talking about their educational

experiences, was proposed. It was also suggested that, as part of the inquiry we would talk and write about the research process. As will become evident the conditions for participation were, in certain respects, specified from the beginning but there was expected to be a degree of flexibility that would enable negotiations to continue about, for example, how often we met and what we spent time doing. Initially however, the plan to meet at two or three monthly intervals over the first eighteen months of their course was agreed and this programme of meetings, in the form of fourteen 'workshops' (seven in each site) was adhered to. Participants were encouraged to read the literature around participatory research and were given a written outline or summary of the methodology.

According to Heron

"statements about persons as agents are true of those persons when the statements are reached by ***procedures*** *that show cognisance of the values of those persons"* (Heron, 1981:33 my emphasis). He refers here to the *"application of norms of* ***language*** *and of other practical procedures by those who generate such norms out of a shared value system. The truths we assert are a function of our procedural norms which in turn are a function of our shared value system. The 'truths' researchers generate are a function of the researchers' procedural norms and underlying values"* (Heron, 1981:33 emphasis added).

What is indicated here is the moral position of those who make truth claims and, as we shall see later, work by Habermas on 'the ideal speech situation' is relevant here for *an ethic of communication* is central to the participation of those in group inquiry. Heron goes on to say that

"for an authentic science of persons, true statements about persons rest on a value system explicitly shared by researchers and subjects, and on procedural research norms explicitly agreed by researchers and subjects on the basis of that value system" (Heron, 1981:33).

The idea of reaching agreement through democratic research procedures is an important premise of group inquiry and the basis on which 'truth claims' may be established yet the extent to which students and myself shared the same values is contentious as we shall see. For research to be 'democratic' *a moral conversation* takes place and this will be discussed in chapter five in order to examine the knowledge claims made using a group inquiry approach. Habermas' work, and that of his critics (especially Benhabib, 1992), will therefore provide a framework for evaluating group inquiry. At the same time however, according to participatory researchers, the

presentational or discursive practices of participants are validated by their experience as encapsulated in the idea of "a participatory universe". This refers to ways of knowing within ' a new paradigm' and raises important epistemological issues introduced in the next section.

5.3 Ways of knowing

Participatory researchers challenge the Newtonian, mechanistic world view that characterises Western philosophy and rather than adopting a fragmented and alienated view of the subjects of knowledge divorced from a separate object world, they use the concept of holism to locate human thought, experience and practice within a complex and seamless web of social and political life and as part of a "participatory universe". The idea of a participatory universe has in recent years been recognised by natural scientists particularly in the new physics.[12] According to participatory researchers such as Reason their approach to research may be seen *"as part of a new world view which is emerging through systems thinking, ecological concerns and awareness, feminism and education, as well as in*

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[12] Accounts of quantam theory (Capra 1992) and chaos theory (Gleick 1987) have drawn parallels between these theories of the natural world and theories of mind (Zohar 1991) and socio-political theory (Capra 1982Zohar 1993). Quantam theory marked a paradigm shift in thinking about the sub atomic world and the solar system and highlighted the limitations of mechanical models. Rather than a world of solid objects that collided with each other in predictable and predetermined ways, the new physics showed how the act of observation/measurement influenced what was seen,"In atomic physics, then, the scientist cannot play the role of a detached objective observer, but becomes involved in the world he observes to the extent that he (sic) influences the properties of the observed objects. John Wheeler sees this involvement of the observer as the most important feature of quantum theory and he has therefore suggested replacing the word 'observer' by the word 'participator'. " In Wheelers own words "in some strange sense the universe is a participatory universe". (Capra 1992:153) For example light may be seen as particles and waves, having seemingly contradictory characteristics. Instability and chaos, immense complexity and multiple potentialities or probabilities are now recognised features of the physical world, and the mechanical view of a solid and fixed object world is now considered inadequate. All knowledge is uncertain and provisional.
It is this reframing of our understanding of the physical world that can also be linked to a 'crisis' in western scientific thought and leads to what, according to Capra is a world view more consistent with Eastern philosophy where paradox and apparently contradictory phenomenon co-exist and complement each other to make up the whole. "In modern physics, the universe is thus experienced as a dynamic, inseparable whole which always includes the observer in an essential way. In this experience, the traditional concepts of space and time, of isolated objects, and of cause and effect, lose their meaning. Such an experience, however , is very similar to that of the Eastern mystics". (p93). Such a radical reformulation of physics seems to have gone almost unnoticed within the social sciences where debates about positivist and scientific methods seem strangely out of date as Woolgar (1988) suggests. Reason then refers to "post-positivist thinking" as characterising "new paradigm research" and challenging earlier theories of knowledge. Theories of knowledge that are also under threat from ecologists and environmentalists seeking a radical rethinking of the relationship between nature and culture.

the philosophy of human inquiry" (see Reason 1988 for a list of other references to support this idea of a new world view). They begin then from a critique of scientific rationality and argue for a reconception of those who take part in research not as objects separate from the knowledge producers but as active and knowing subjects who *co-produce* knowledge. This emphasises the intersubjective process of knowledge production, the need for a shared language as a means of representing to each other a view of the world. For these researchers, the consequences of reflexively asking *"to what kind of explanation of my own research behaviour am I committed?"* (Heron, 1981:20), that is in what sense do I 'know'? points to a similar question about those we research. If then the subjects of research are relatively autonomous, *"self-directing and intelligent agents"*, Heron says that human inquiry must take account of this. He therefore argues on a number of grounds that human inquiry should be *co-operative*. This means working collaboratively with groups to produce knowledge that is for them, that has an emancipatory agenda and is action oriented. He does not support the idea that knowledge production (research) is the domain of acadamic elites (social scientists), that objectivity is either possible or desirable.

In recalling the philosophical basis of this approach and the work of John Heron, Peter Reason (1988) refers to the alienated knowledge of conventional or 'orthodox' approaches where those who take part in research are alienated from the product of the research, the work of the research from other people and from themselves. In contrast, participatory researchers seek to integrate different ways of knowing and being in the world, to bring together *experiential* knowledge, *propositional* knowledge and *practical* knowledge and in so doing to promote holistic knowing.
"Such an approach would involve all actors in three forms of knowing: propositional knowing, or knowledge about, which takes the forms of ideas, propositions, and theories; practical knowing, or knowledge how to which takes the form of skills and abilities; and experiential knowing, or knowledge by encounter from sustained acquaintance face-to-face, which is tacit, intuitive and holistic" (Reason, 1988:4).
Reason uses the term 'critical subjectivity' to refer to going *"beyond the split between objective and subjective"* and raising to consciousness *experience* in order to critically analyse it and use it as part of the inquiry process. He suggests that participants achieve a level of awareness and self -realisation that is not possible in other forms of research. The emphasis on experience points to the humanism at the centre of this approach and a

materialist understanding of knowledge production which, as we have already seen, is controversial. By contrast, I shall argue in chapter six for a discourse theory of knowledge.

Knowledge production in participatory research is seen as an emergent process, whereby the researchers work together in a group to better understand their experiences, to know themselves and each other better, and together to act in ways that challenge previous knowledge. According to this view, research is both a personal process (Marshall, 1981; Reason & Marshall, 1987) and political, it is educational and radical in that it seeks to develop new forms of collective understanding and action. As a participant in group inquiry therefore I anticipated that we would reach an agreement about what becoming a midwife could mean which would provide a basis from which to act in the future development of midwifery education. I hoped that through such action the emancipatory aims of group inquiry could be realised.

5.4 Emancipation

The concept of emancipation is contingent on an understanding and experience of *oppression* which in turn relates to constraints on a person's actions or thoughts. According to critical theorists the opportunity to stand back from one's experience, to become 'critical' of it is an important pre-requisite for action that will bring about social change and overcome oppression. A principal aim for participatory researchers is to *empower* participants through the research process, enabling them to become critical and thereby create a force for change. Changes might then occur by both individual and collective action as a *collective consciousness* develops through the dialogue that takes place.

This Enlightenment model is adopted by participatory researchers. Patricia Maguire explains

"this three-part process of knowledge creation is more than a set of research techniques. It is a systematic approach to personal and social transformation. Participatory research aims to develop critical consciousness, to improve the lives of those involved in the research process, and to transform fundamental societal structures and relationships" (Maguire, 1987:3).

It is seen as consistent with the emancipatory aims of educational and community development projects that draw on the work of others such as Paulo Freire (eg Tandon, 1981). Yet Maguire asks
"exactly which people are empowered and which social structures are challenged? When participatory research claims to empower a community or group, are the women in the community equally as empowered as the men? When participatory research declares its intention to oppressive social structures, is patriarchy one of them?" (Maguire, 1987:50)
She suggests that women and gender have not had a central place in participatory theory or practice and writers such as Reason & Rowan (1981) have been criticised for their "male biases", though they acknowledge the weakness of their work in this respect. She identifies the following *"androcentric aspects of participatory research"*: Male-centred language; Women's unequal access to project participation; Inadequate attention to obstacles to women's participation in projects; Women's unequal access to project benefits; Unsubstantiated generalization of the benefits from primarily male project to women; Absence of feminism from theoretical debates on participatory research; Exclusion of gender issues from participatory research issues agenda (Maguire, 1987:51-52). She seeks to put women centre stage, to see the oppression of women as central and a feminist approach to participatory research as seeking *"the emancipation of women and the creation of a just world for everyone"* (Maguire, 1987:79). She aims to promote dialogue between feminists and participatory researchers.

Like Maguire I saw group inquiry as part of an explicitly feminist agenda and believe that feminist theory can make an important contribution to participatory research. In particular feminist participatory researchers take a *'reflexive dialogic approach'* (Gergen & Gergen, 1991:86) and in addition to attempting to share power with co-researchers provide an analysis of the conditions under which that dialogue takes place. Conditions which may be described as patriarchical and where inequalities are reproduced in the production of knowledge. My aim is to focus attention on the extent to which a democratic procedure for this research could be seen as overcoming inequalities between those who took part. For in defining participants as 'co-researchers' working together to produce accounts of becoming a midwife did this imply that we were all equal?

Conclusion

In group inquiry, as a form of feminist participatory research, I aimed to adopt a procedure that was democratic, that would give voice to the accounts of 'others' and in so doing challenge a hierarchical view of knowledge production. By seeing knowledge as discursively produced, through dialogue with others, like other participatory researchers, I sought to challenge the orthodoxy of scientific method. The view of participants adopted was one of citizens speaking from experience constructing accounts of what it means to become a midwife. However as will become apparent during my analysis of the inquiry process, certain liberal assumptions underpinned this approach.

The concept of citizen or participant may be seen as a universalist and ungendered one (Walby, 1994) for it takes no account of the different positions of participants and the power relations that remain in the inquiry process but rather assumes that all participants are equal. It is as though an ideal speech situation is thought to already exist and communication is undistorted. Moreover a holistic way of knowing and being in the world which requires us to go beyond the object-subject split did not address the problem of representation. For how, after all, could the inquiry be represented in the research report? What representational practices would be acceptable that did not return to a hierarchy of propositional, experiential or practical knowledge? Would making myself accountable to the group for what was produced, (rather than setting my version of the research (as analyst) above theirs) satisfy some kind of moral and ethical standard? Finally, given a recognition of diversity within the group could there be any basis for collective action and solidarity? By siding with them was the possibility of an emancipatory project likely to be realised or not?

These were some of the questions and concerns that have been highlighted in this chapter through a discussion of the debates around science and ideology, and between feminists and postmodernists. By adopting a democratic approach to research and evaluation I remained firmly within a modernist project but by wanting to engage with a discourse theory of knowledge, in recognition of the centrality of language in mediating both subject and object relations, I was led to question the liberal ideals underpinning such a model. Part 1 has introduced the voices of midwives (in chapter one) and sociologists in order to set the scene for the dialogue that took place between myself and the student midwives during *group*

inquiry . In Part 2, the next two chapters continue the story of the inquiry process and represent the accounts of becoming a midwife that were produced by each of the two groups. As will become clearer, by introducing group inquiry method and the three themes of participation, ways of knowing and emancipation, I have provided a framework for understanding midwifery discourse and politics, and tensions within the inquiry process itself. In Part 3, chapters five and six will return to these themes, in the light of group inquiry.

PART TWO - *THE DIALOGUE*

General Introduction to Part 2

In the last chapter I outlined how group inquiry was set up as part of the national evaluation project. In two of the six case study sites it was agreed with the heads of midwifery education and other staff in the education and service institutions that students on the pre-registration midwifery diploma programme would be invited to take part in an inquiry that would take place over eighteen months commencing in the Autumn of 1991, soon after they began their course. In each case, it was agreed that time would be set aside on college days for a series of workshops to be arranged at two or three monthly intervals. The main features of group inquiry as a form of participatory research, were outlined to these 'gatekeepers' and they also agreed to make available a room where the workshops could be held. Their support for the inquiry was given in the context of their willingness to take part in the national evaluation project and therefore was in addition to the other ways in which they participated in that project (eg individual interviews). In the case site where Group inquiry 1 was located, other students on a pre-registration midwifery degree programme were interviewed individually and later in a group interview.[1] The results of these interviews and a fuller discussion of each of these two case studies is found in the evaluation report (Kent et al 1994). In the remaining four case study sites, students were interviewed individually soon after they began their course and in a group approximately a year later. *Group inquiry* however, provided an opportunity to explore in more depth students' educational experiences on two of the three year diploma programmes, and to generate an alternative method for constructing accounts of becoming a midwife. In Part 2 of this thesis, chapters three and four report on Group inquiry 1 and 2. These two chapters re-present the dialogue that took place between myself and two student groups over an extended period of fieldwork. As already indicated the purpose of this dialogue was to explore, in depth, the students' educational experiences, and to examine what becoming a midwife meant to them. Each chapter also explores the research process and identifies key issues related to group inquiry method.

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1 This case site was unusual because it had both a pre-registration midwifery diploma and a pre-registration midwifery degree programme (see fig A)

In selecting each of the six case study sites, the institutional arrangements for providing pre-registration midwifery education were considered significant in shaping the educational programme. The two sites for group inquiry were distinctive in a number of respects and figures A, B and C below illustrate important features of each case.

GROUP INQUIRY 1 (Chapter 3)

The setting for Group inquiry 1 was a College of Midwifery and Nursing in the south of England. The "case" comprised a set of institutional arrangements for providing pre-registration midwifery education which initially was represented in diagrammatic form as Figure A but, following further re-organisation in both education and the National Health Service took the form of Figure B.

Figure A 1991

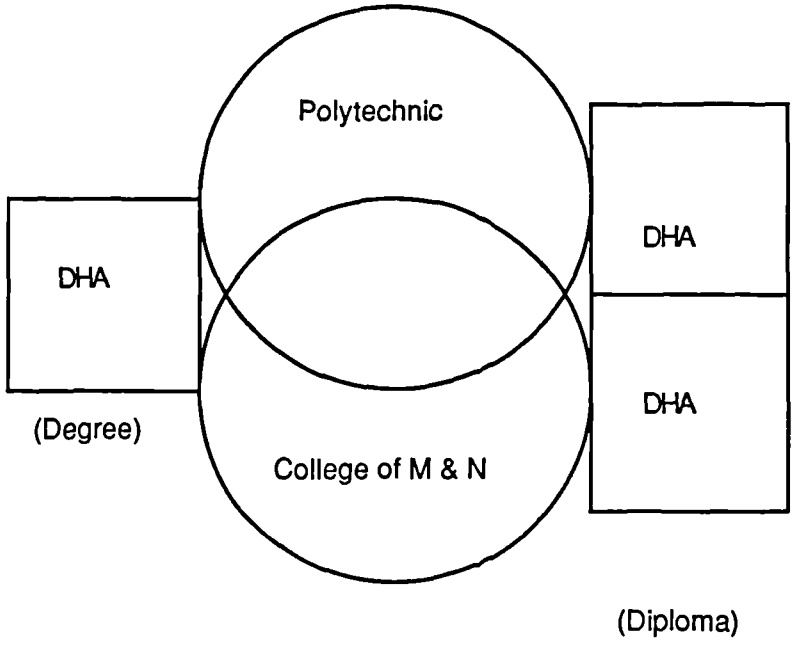
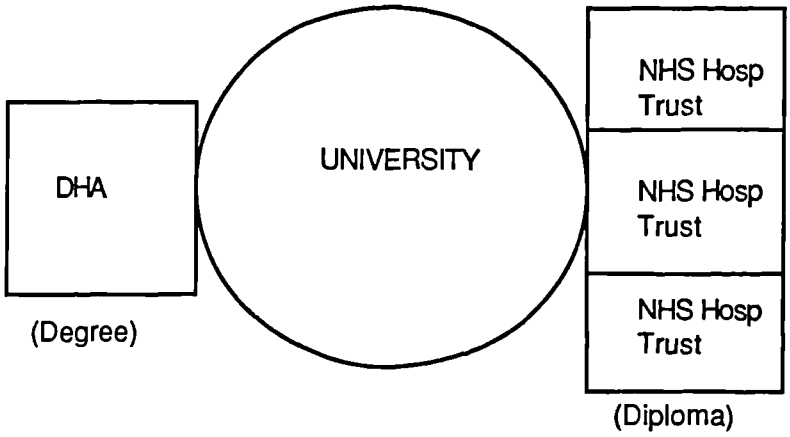


Figure B 1993



The pre-registration midwifery diploma course began in 1989 when links with the Polytechnic were first initiated. The course was funded by two district health authorities where students had placements in each of the three maternity units and two district community services. Subsequently, in 1990 a new pre-registration midwifery degree course was set up but midwifery students on this course were placed in a third health district. In 1992 the College was dissolved and became integrated into the polytechnic, later to become a new university in 1993. Concurrent changes in the National Health Service led to the formation of three NHS hospital trusts and further developments in midwifery services took place with the closing and relocation of one unit at a new hospital site. These changes will be seen as having important consequences for the students in their account below.

Diploma midwifery students had some joint lectures (shared learning) with nursing students on the diploma nursing course which in 1991/2 became a P2000 course. Entry requirements to the diploma course were the UKCC minimum of five GCSE's (or equivalents). Each intake comprised up to sixteen students and those invited to take part in group inquiry began in September 1991.

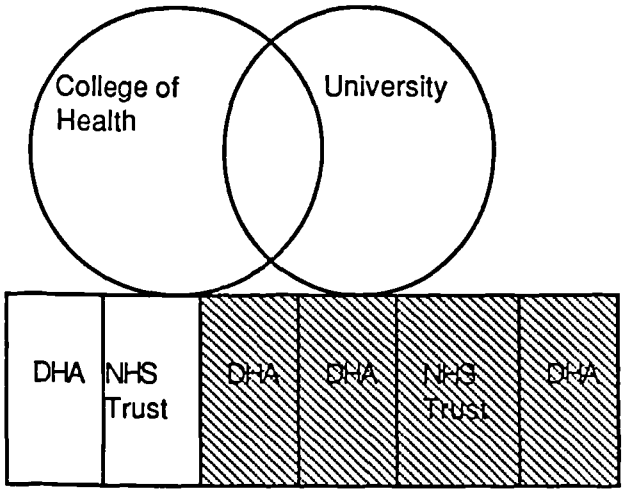
GROUP INQUIRY 2 (Chapter 4)

The setting for Group inquiry 2 was a College of Health Care Studies in the Greater London Area. The college was formed in 1990 following a series of amalgamations and, for the purposes of the pre-registration midwifery diploma, was linked with a polytechnic. The course began in 1990. It was

funded (twelve places per year) by one district health authority where in 1991 the hospital became a NHS trust. This had a significant impact on the management and organisation of midwifery services when redundancies and poor staffing levels ensued. The course was based at this hospital site, where students gained practical experience, away from the main College. Students seldom went to the polytechnic except for some lectures during the first year. There was no shared learning[2] with other student groups. In 1992 the polytechnic became one of the new universities. (see figure C).

Entrance requirements to this course were a minimum of two A'levels (or equivalent) for applicants under twenty one years of age and the UKCC minimum for others. The 1991 student group took part in the inquiry.

FIGURE C



▨ Other agencies purchasing education from the college but not used for pre-reg midwifery.

2 Shared learning refers to an arrangement where students from different courses attend lectures or teaching sessions together for part of their course. In pre-registration midwifery courses it is common for midwifery and nursing students to share some lectures but is by no means a universal feature as this course illustrates.

A NEW LITERARY FORM?

Chapters three and four give two separate accounts of becoming a midwife via the pre-registration route and tell the story of group inquiry at each of these two sites. Each of these is a product of the dialogue that took place over eighteen months between myself and the students. The format of these two chapters is significantly different from the previous ones in Part 1 and this needs some explanation.

I shall begin with an introduction to each of the student groups and an overview of the diploma programme and inquiry timetable in each case. Subsequently the chapter divides into two parallel sections - one refers to *CONTENT* and the other to *PROCESS*. Given the preceding discussion of the democratic intentions of this inquiry I wanted to adopt a procedure that would give voice to all those who took part in the workshops. While there were a range of experiences and differences between participants it was agreed at the outset that the report of group inquiry would be 'co-produced'. In effect this meant that we were to seek an agreement about what would be included in it and how it would be written. In practice we attempted to explore a range of issues that came up during the inquiry and to document them using a combination of individual and collective writing, notetaking and tape recording. Over the eighteen months a considerable amount of material was generated and as Atkinson explains, writing up is seen here as *"a complex layering of textual production"* (Atkinson 1992:5). Recognising explicitly the *"intertextual"* relationship of the material produced, the way in which, as textual products, fieldnotes, workshop feedback and research diaries, relate to, or are mediated by each other, these chapters may be understood as what Atkinson refers to as a *"bricolage"*. The accounts of becoming a midwife and the story of the inquiry are a kind of *"collage"* where pieces of these earlier texts (data) have been carefully arranged and re-presented here to produce a readable text (Atkinson 1992:41). At the same time, these chapters highlight the ways in which *"textual conventions do not merely raise technical or methodological issues: they have moral consequences"* (Atkinson 1992:6), in so far as they configure a set of subject-object relations between the participants in the research, the author/writer of the text and you, the audience/reader. These relations, mediated by the text are discussed further in chapter six but the format of the next two chapters serves to draw attention to and problematise them.

The two accounts produced here under *CONTENT* represent a form of collective writing, the culmination of both individual and collective effort to produce an account of becoming a midwife that could be accepted as 'representing' the views and experiences of those in each group. [These two sections on *CONTENT* were reproduced in the evaluation report (Kent et al 1994).] By a recursive process of feedback, reflection and discussion, each group made suggestions, about what could be included in the account (see workshop 7). There were inherent difficulties in this which will become apparent in the next two chapters especially through the stories told here of the inquiry *PROCESS*. I wanted to tell these stories in order to explore the process of how the groups' accounts of becoming a midwife were produced. For, as a reflexive project, I considered it necessary to include this, not as a way of enhancing objectivity, as perhaps Harding (Harding 1986; 1991; 1993) would suggest, but as a means of examining 'subject positions' and the way in which they too were discursively produced. It would therefore provide a means of examining methodological issues inherent in the group inquiry approach. This attempt to reach an agreement presents both theoretical and practical problems about the legitimacy of such an agreement which I believed could to be explored with reference to a parallel account of the context in which it was produced, or rather with reference to the inquiry process itself. For me this did not imply a hopeless and pointlessly infinite regressing of stories about stories about stories, but rather a practical strategy that could have some value in explicating what these problems might be. I will elaborate on these further in chapter six.

The accounts of becoming a midwife are told in the first person, as if a student is telling a story and while this may appear univocal and exclusionary, reference made to 'others' in the story, points to areas of diversity within the group. This is not intended to signify closure or indeed that this account is the only one that could have been written. Instead the procedure or method for writing it gives it a legitimacy and validity that may be defended and accepted. Use of the first person singular 'I' serves two purposes. As a literary device it provides a coherence to this account by creating a fictional character, a 'subject' who speaks, or an authorial voice to tell it, in so doing it is intended to persuade the reader of the authenticity of the account which tells them about the experience(s) of being a student midwife. In these accounts it also represents agreement amongst the group, signalling that this account is accepted as standing for, or representing them.

Its function then is rhetorical but also political, for it enables the group to speak as one. Here then the use of the convention "I" is in some senses unconventional and the idea of a fictional character being jointly produced by the group indicates a blurring of the boundaries between 'fact' and 'fiction', a rejection of absolutist notions of 'truth', and an attempt to produce a consensual account. This in turn is to be regarded as simply one way in which accounts of becoming a midwife may be constructed.

In contrast the use of "I" in the story of the inquiry *PROCESS* has a different value, though in other respects is similar. As a literary device it has a similar function for the reader is persuaded to regard this 'diary' as the voice of the author JK. Yet in constructing this story I have drawn on a range of sources, including fieldnotes and a research diary, together with workshop notes that were written throughout the eighteen month period. Unlike the account of becoming a midwife or the account of process (in appendices 9 and 16) the students in the two groups were not consulted when this was written. In this space, then,'the sociologist' speaks and the sociologist, as subject, is both constituted and asserted. In this way "I" am both set apart from the group, writing about the inquiry process, but I am simultaneously situated as part of the dialogue. Politically then this device emphasises differences within the group, differences between myself and the students, and as such "I" stands for me, who in this context has a single voice. By presenting this story in parallel to the accounts of becoming a midwife my intention is to illustrate intertextual relations and the dialogue between the students and myself. While adopting what may be seen initially as an 'alternative literary form' (Woolgar 1988; Atkinson 1992; Cooper 1993) I therefore use textual devices that draw on other literary conventions. The narrative form of the student becoming a midwife and the form of a 'diary' adopt literary styles that are necessarily conventional for them to be intelligible and readable.

It is therefore possible to draw from these two accounts of students on two different diploma programmes what were salient and important issues. These are elaborated in chapter five using the three themes introduced already of participation, ways of knowing and emancipation. It becomes evident through this analysis that what it means to 'become a midwife' may be usefully understood as the assertion of a subject position that relies heavily on the valuing of practical skills and knowledge for the emancipation of women in, and during, childbirth. From the two stories of

group inquiry it is possible to elaborate on some of the theoretical and practical problems of inquiring together and I shall take up the issues raised here in chapter six. Using the same three themes I will examine the conditions for participation in group inquiry, the status of claims to knowledge made and the emancipatory potential of a feminist participatory approach to this research.

CHAPTER 3

GROUP INQUIRY 1
"A New Beginning"

Introduction

I shall begin here by introducing the participants of Group inquiry 1 before going on to give an overview of the diploma programme and the inquiry timetable. What then follows is a group account of becoming a midwife and a story about the inquiry process. Finally I identify some central issues which will be discussed more fully in chapter five and six.

There were sixteen students who began the diploma course in September 1991 at this site and all were invited to take part in group inquiry. In addition, for the purposes of the evaluation and in order to collect some basic data about the students, each of them was asked to complete a short questionnaire giving some personal and biographical details. Of the sixteen students, eleven returned a completed form. The group ranged in age from 18-45 years old but eight (80%) were over the age of thirty one. They were all white women and seven had one or more dependent children. Their academic qualifications were listed and showed that three had less than five GCSE's (or equivalents) and three had successfully sat the DC entrance test which is accepted by the UKCC if formal academic requirements can not be met. Two students reported sitting a further test for admission to the course - writing an essay. Five students had no A'levels (or equivalents), five had one or more A'level and one had a first degree. Three already had other professional qualifications and previous experience included.-nursery nursing, home care assistant, nursing auxillary, health care assistant, market gardening, market research, masseuse, school lunchtime supervisor (p/t) and teaching (p/t). Five had come to the course from employment while two had been self-employed. One had come from university while two had previously been full-time mothers, and "housewives" (one student

completed only a shortened questionnaire and did not give details of her previous experience or what she had been doing before the course began.)

Consistent with the group inquiry method a few details of the sociologist are considered of relevance. When this inquiry began I was thirty four years old - a white woman, with two dependent children. Formal qualifications included ten GCSE equivalents (O'levels), one A'level and a first degree in 'Sociology with research training.' I was also a registered general nurse with experience in intensive care nursing. As already indicated, at the time of this research I was working as a research officer/project manager on the evaluation project. The group knew of my background and something of each others personal history though the specific details of the questionnaires was not formally discussed during the inquiry.

The diploma programme was three years in length and the curriculum documents provided an overview of the organisation of the students' education. Their time was to be divided between taught sessions in the College or polytechnic (later to become the university) and practice placements in maternity services and primary care. A feature of this programme is that after an initial four week block in college, each week is split between College and service settings, with an increasing amount of time spent in practice as they progress (see Table 1). During the first year students are introduced to midwifery practice in both community and hospital environments. In the second year they gain experience in general nursing before returning to midwifery areas. They were due to qualify in October 1994. Due to the circumstances of the inquiry being carried out during the national evaluation project it was agreed the workshops would run for eighteen months. Since the evaluation project was to be completed by autumn 1993 this would allow for a preliminary account of group inquiry to be included in the final evaluation report. The time and commitment of the students to participate in an eighteen month inquiry was considerable and although the possibility of extending it was not ruled out, in the event it seemed that they would not be able to sustain this level of commitment or the time to continue meeting so regularly and neither could I. The last workshop therefore was held in May 1993 though a follow up letter was sent out in October 1994 to ascertain who had qualified and the students' views of the course and the inquiry at that time (appendix 8).

TABLE 1 Overview of the diploma programme and Group inquiry.1

(for an outline of each workshop plan - see appendix 10)

Date	Diploma Programme	Group inquiry 1
1991 September	Students began with an introductory block of four weeks in the polytechnic and for the first three semesters (until March 1992) have shared learning with P2000 nursing students on the common core programme for 3 days per week.	
October	Community placements for 2 days per week including (10weeks)	Introductory workshop : *Meeting the students -A new beginning*
December	Placements in primary care and paediatrics 2 days per week (10 weeks).	
1992 January		Workshop 2: *Focussing the inquiry-Becoming a midwife*
March April	First hospital placements on maternity wards (labour/antenatal/postnatal) two days per week.(24 weeks)	 Workshop 3: *Managing conflict - Getting some practice*
July	Planned integration of College of midwifery and nursing into the polytechnic/university. On hospital practice placements three days per week.(18 weeks)	Workshop 4: *Constructing accounts-Gaining confidence*
November	Students relocated at the university.	Workshop 5: *A sympathetic listener - A traumatic time*
1993 February		 Workshop 6: *Keeping a critical distance - Developing practical skills*

March	Second community placement for 4 days per week (6weeks)	
May	Placements in general nursing areas began - gynaecology, theatre, medicine, psychiatry (10 weeks)	Workshop 7: *Writing a report on group inquiry*
September	Maternity allocations 4 days per week, 1 day study leave.(each allocation in a maternity area lasting 6weeks).for final year.	
1994 October	Students qualified	Follow up letter (see appendix 8)

Notes: Throughout this programme one and two week holiday periods are scheduled totalling 22 weeks over the three years. Approximately three additional study blocks of one week are also scheduled. The programme was subject to changes and revisions in the stated allocation plan due to changes in the service areas. Since the students spanned three hospital sites it is not possible to say on which kind of maternity ward they would be working at any one time since individual students' programme would vary. The sources for this table therefore include both the curriculum documents and the students' own diagrams of their individual programmes which were created during workshop 6.

Through out this research PROCESS and CONTENT can not easily be separated since they are considered interdependent, each in dialectical relationship to the other. In order to portray this relationship the following sections are arranged in parallel and may be read across the chapter. Time is an organising principle though even this is problematic since the accounts were actually written at different times. The different sections may be seen as illustrative of different voices participating in this dialogue and therefore are visually distinct in order to 'sound' different.

CONTENT is an account of being a pre-registration midwifery student on the diploma course. As already explained in the general introduction to Part two, it is written in the first person, as if a student is telling a story about becoming a midwife but represents the views of the group expressed in the inquiry, rather than recounting a story of any particular individual. As such

it is a consensual account but indicates diversity and differences of opinion with reference to 'others'. This section includes the substantive content of the workshop discussions and is the product of the dialogue between members of the group. It was co-authored by the group (see workshop 7) and was reproduced in the evaluation report (Kent et al 1994). It is the culmination of a lengthy process of joint discussion and analysis over the eighteen month period, and provides a first level analysis of what it means to become a midwife via this pre-registration midwifery diploma programme. A summary of key issues and concerns highlighted by this account is presented at the end of the chapter and these will be explored in more depth in chapter five.

PROCESS- tells the story of the inquiry itself and is written by me in the form of a 'research diary'. Written in the first person singular this story of group inquiry represents the view of a single author. It details my view of the inquiry and is a revised and edited version of fieldnotes, workshop feedback and diary notes kept throughout this period. However I also referred to what it was like for the students taking part in the inquiry and in so doing drew on a separate account that was agreed with them and reproduced in the evaluation report (see appendix 9). That account of the inquiry process was constructed using workshop notes and fieldnotes and the students own suggestions of what should be included in 'writing a report' (see workshop 7). As already indicated the intertextual relations of this section and those earlier records are recognised and the 'diary' format is a literary device for telling a story of inquiring together. As such it is a creative attempt to point to what were important practical and theoretical issues raised by the group inquiry method. Issues that are summarised at the end of the chapter and discussed more fully in chapter six.

WORKSHOP 1 A new beginning

My reasons for deciding to become a student midwife fell into three themes or categories - I had an interest in health, an interest in women and childbirth and I wanted to become a professional. It was like a 'new beginning'. I wanted to be involved in promoting health, and working with healthy people. By training as a midwife I saw myself as dealing with something I could relate to - being a woman. I would encourage others to be strong in themselves, and would make childbirth a fulfilling and happy experience. I hoped to gain job satisfaction by working in a caring profession and by having a lifelong career, perhaps even the chance to travel abroad. I expected a job at the end of my training and job security.

Becoming a midwife meant many things to me. I saw it as a career step and a profession for life. It meant a change in lifestyle with less money and the new demands on my time meant my social and family life would be altered. I expected my personality would develop as I learnt to become more assertive, and self aware. I hoped I would become more tolerant and open-minded towards other people. Being a midwife meant being dedicated and hard-working. I thought by becoming a midwife I would grow as a person, become fulfilled and have job satisfaction. Caring for others I also anticipated being able to develop new skills and knowledge which I could pass on to others. I wanted to become good at communicating with others without judgement or prejudice. In the longer term I expected to gain in confidence and be able to cope with stress and responsibility. I was happy to be on the course and hoped to enjoy the experience of becoming a midwife.

Early in the course I had both good and bad experiences. There were a range of good experiences which were mostly related to the clinical placements and at this early stage I identified with the clinical practice and

OCTOBER 1991 Meeting the students

A date for meeting the student group was agreed with their tutor and I sent a letter to the students explaining the purpose of the meeting [see appendix 11]. The letter emphasised the voluntary nature of participation in the research and enabled people to consider before the meeting whether they would like to take part as the issue of informed consent was an important one.

I presented an outline of the evaluation project in brief (perhaps hurriedly) and introduced the idea of group inquiry. I explained that the work would be used for both my PhD and the evaluation - their involvement would be meeting 3-4 monthly to explore and analyse their experiences. I emphasised that it was an individual choice about whether they got involved. Some were more keen than others but all the fourteen students present agreed to take part (two other students were absent but the group felt it likely that they would want to be involved).

Potentially the size of the group was a problem ..If necessary the group would decide how best to tackle this. It would have been possible to divide into two groups but this seemed contraindicated because: more of my time and resources would be needed; the relationship between two groups may become competitive; arranging two meeting times would disrupt the college timetable for much longer; some

was keen to gain hands on experience which I most enjoyed, I especially liked being out with the community midwife. Seeing a birth was good and hearing a foetal heart for the first time was also a positive experience. I also enjoyed going to a caesarian, doing a postnatal check and meeting a qualified direct entry midwife on the community. Participating in care and looking after a woman who I followed in the community and hospital was a good experience. I was also pleased to receive a fifty pound book token!

Other early experiences were less positive and I fainted on my second day which was definitely a bad experience! I found that I didn't like going to the polytechnic. I felt strongly about this and I didn't like the atmosphere there or being one of a small group of midwives in a much larger group of nurses. Everything seemed geared to the nurses. On the wards I sometimes felt other midwives resented me and there was a generally negative attitude towards pre-registration midwifery students.

I was looking forward to learning and gaining practical experience especially doing a delivery and I looked forward to the day I would become a qualified midwife. But I was anxious about the prospect of exams, having to deal with emergencies and being legally responsible for what happens. I really wasn't looking forward to eighteen months at the polytechnic and I was anticipating that there would be personality clashes on the wards when I would have to stand up for myself in the face of the negative attitudes of other staff.

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group members would probably drop out over time. So what size was viable for group inquiry?

Democratic participation?
Everyone seemed to enjoy the first workshop. Lots of material was thrown up. Perhaps we should have analysed it more but at this stage I'm not sure it would have helped. I was concerned that my role in the group was likely to continue as leader, facilitator and teacher. It seemed that clarification of roles especially what it meant to be a 'co-researcher' was necessary so that I could share responsibility for 'managing' the group process.It seemed important for the group to reflect on the research process and group dynamics and therefore I resolved to build this into future sessions.

The workshop approach used in this first meeting worked well and helped break the ice. The meeting was taped but I turned it off when small group discussions took place. Some of the students were nervous about being recorded and found the process rather daunting at first. We talked about what being a midwife meant and why they had joined the course, writing notes on flipchart as we went. It was essential to reflect on the material generated, at the next workshop.

WORKSHOP 2 Becoming a midwife

Initially I was anxious and apprehensive about going out with the community midwife and the first contact I had with clients. It was exciting being present at a home birth and watching an experienced midwife work. The skill with which she worked and the close relationship she had with the mother was amazing and interesting and I began to understand more about what becoming a midwife meant. When I had the chance to get to know a woman during her antenatal care I felt much more involved and emotional at the delivery of her beautiful baby girl. After all the whole aim of being a midwife is to produce a healthy mother and baby at the end. At this time I often felt inadequate and unsure of myself but when I did manage to accomplish something I felt spurred on to new challenges and when I was successful I slowly began to gain in confidence as this account of a significant event illustrates:

JANUARY 1992 **Focussing the inquiry**

The role of theory

I was constantly thinking about the role of theory in research and group inquiry in particular. What was the role of theory? What was theory? Since the purpose of the group inquiry was not only to describe the experience of 'becoming a midwife' but to *explain* it. The extent to which "grand theory" had a place in group inquiry was a real issue. I wanted to challenge theory with experience (see Haug 1987; Stanley & Wise 1993). My problem here was to what extent could, or should, formal theory to be part of the research? And what was my role as "a woman of theory" in the sense which Haug et al used this phrase (Haug 1987:282)?

I was unhappy about imposing my definitions or explanations of their experiences on the group. To introduce formal theory may in effect amount to exactly that. If instead the group was encouraged to generate their own explanations for their experiences in a "grounded theory" approach how could we move beyond those subjective experiences? Or by the very process of generating grounded theory would we develop an "objective" account of becoming a midwife?

A thematic approach

Initially I decided to adopt a thematic approach to the workshop data - this would hopefully enable the group to begin considering how they might draw conclusions about their reasons for becoming student midwives, and what being

Developing Skill (this was one of several accounts of significant events written by group members)
"Jane was becoming more and more obsessed with the fact that she could not grasp the concept of blood-pressures. She felt totally inadequate and positive that she would never master the skill. Her community midwife seemed to be getting a bit annoyed and had told her that she was sure she wouldn't hear them as it had become an obsession and that she was trying too hard. No-one else in the group seemed to have any problems and all kept reassuring her that it was easy and she would soon get the hang of it.

At one of the lectures in college a tutor went over the blood-pressures, saying that a lot of people wrote down misleading recordings as they rounded up to the nearest 5 or even 10. That some actually took the readings at the wrong levels. Jane listened very hard and hung on every word that Mary said. She went on to explain how to take a blood pressure properly and faults a lot of people make. Jane suddenly felt confident and a lot more positive than she had felt for a long time.

When next on community and asked to do a blood-pressure, she took a deep breath, carefully placed the cuff around the lady's arm and palpated her arm, yes! she could definitely feel the pulse and when it stopped. She made a mental note, placed the stethoscope on the lady's arm and repeated the process. She could not believe the faint thudding in her ears, and repeated the exercise once more, yes she was sure 120/70, she proudly told her midwife, who smiled encouragingly at her. After that day Jane never looked back, it had been a very significant point in her training. It made her feel positive and completely confident she would overcome any further obstacles."

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a midwife meant. Themes identified might provide topics for consideration at future meetings when we could examine why they were significant and their importance (or not).

There were six people absent. Everyone had had a bad day and some of them were feeling that they didn't want to do the research. I would contact the absentees by letter.

We went over the aims of the research as one of them asked "what is the research for?" I asked how they viewed the feedback from the last workshop. Some said they it was interesting and agreed we had covered a lot of things. We then began to look for themes.

It was evident that many of the group had not been systematic about this task and one or two were unclear about what we were trying to do looking for categories/themes by grouping things together. Some found the analysis difficult others had less difficulty. We identified eleven themes in all.

As a group they were very willing to accept the suggestions offered by a member or myself. They were unquestioning and uncritical. This led to a rather curtailed discussion and my role seemed more one of encouraging and drawing out ideas, making suggestions when no-one had anything else to say.

So being able to do basic practical things like taking a blood pressure or listen to a foetal heart with a Pinard stethoscope was very important to me. Though these were small steps they were very steep and I hoped that the view from the top would be worthwhile. This account was a good indication of the progress I had made. While some of us learnt to do things quicker than others it was not a sign that they would be less good as midwives, we all needed practice and time to develop these skills which in turn built up our confidence. At the same time I recognised that the relationship between a midwife and her client is a very special one.

In small groups they talked about "significant events" - only three or four people had written their accounts so I encouraged everyone to think of something to discuss. The "guidelines" (appendix 12) were not closely adhered to and indeed some group members simply said "seeing a birth" was the significant event but were less ready (or able?) to explore why or what was learnt from this.

I tried challenging the group so asked "what is so special about childbirth and being at a birth?". It seemed that the group were unable to step back from their experiences. I gave out some short evaluation sheets at the end - this was a chance for individuals to disagree or agree with the group's conclusions. (see appendix 13).The atmosphere of the session had been light hearted though they complained about the course. This led to a brief discussion regarding the value of research and whether it had a part to play in bringing about change.There were mixed views on this.

Afterwards a student, who had made it clear during the workshop that she was not going to fully take part, stayed behind.She told me she had no confidence in research and she didn't like being researched. She was not going to talk while the tape recorder was on and would not write an account since what happened to her was "private". She was unwilling to share anything. So there were divisions in the group which made me feel uncomfortable.

WORKSHOP 3 ***Getting some practice***

In the second six months of the course I spent two days a week in the practice areas in hospital and three days in school. Most of my energies were taken up with the placement experiences which I found stressful and some in my group were not sleeping well. After getting home from a late shift I sometimes spent the night worrying about what I would come across the next morning. There was no-one to talk to about how I was feeling but I got by. A friend of mine fainted while she was double scrubbing, partly because she hadn't been able to sort out her coffee or lunch break but also from stress and anxiety. (The fainting later disappeared as she became able to control her anxiety). I learnt other skills - giving injections and doing VEs (vaginal examinations) but there were still occasions when I felt very unsure of myself and some of the confidence I had gained in the community deserted me in the unfamiliar hospital situation.

Some of us were allocated to work in labour ward while others were working across clinical areas following women and working within a system of team midwifery. We all had very different experiences according to where we worked but we were learning some of the same skills.

I didn't work with my mentor very often so I didn't feel that I got much support but there were others in my group who had some good teaching. It made such a difference if someone told you that you had done okay but often I had to pretend I knew what I was doing for the sake of the woman. At that time I felt in the middle, between the women who I could relate to and the qualified midwives. Most of the midwives didn't seem to know much about the course or pre-registration midwifery education and no-one could tell the difference between us and the other students so I think there were occasions when they expected too much of me. At the same time others didn't realise that there were things I could do and that I had other experiences and learning to draw on. It really was difficult fitting in with the

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APRIL 1992 **Managing conflict**

The tutor showed me into the classroom. Four students then left the room - one telling me she would come next time . For a few minutes it was unclear who was going, who was staying and immediately I began to feel uncomfortable again. The conversations stopped as I walked in. A student said she had seen an article I had written and thought "oh maybe something will be done about the course after all." They asked me about students on other courses but I said I couldn't really comment.

I asked what had been happening to them. As I set up the tape recorder the same student said she wouldn't talk while the tape was on but would listen or write things down since I had asked for someone to take notes. But others said if she wasn't going to participate she shouldn't stay so she put her coat on saying she would accept the majority consensus and would leave- no-one tried to stop her. I felt the group were uncomfortable with her presence. Since she was not willing to contribute it seemed best she went. After all she was of the view that research had no value, so her staying may have been disruptive. I told the others that only those who wanted to contribute should take part. Someone said that they had just had a session on tensions in the group but other students had not stayed for quite different reasons. Evidently tensions within the group had spilled over into the inquiry leaving seven at this workshop.

hospital system, the hierarchy in particular. I also found the shift work very tiring but I thought I would get used to that in time.

There were things I would have liked to change. I really wanted more support from the tutors and encouragement. Support from teachers, mentors colleagues and friends was important for me to endure the course and looking back I feel it would have been beneficial to have at least one person to confide in. If we had clear objectives or goals for each month I think that would have helped because the chance to practice skills was really just a matter of being in the right place at the right time. I would have preferred to spend more time in the practice areas working alongside a mentor and blocks of practice rather than a split week would have given me more continuity with both mentors and women. While this had already been suggested by previous student groups it seemed that midwife tutors were able to do little to improve or change the course. It also would have been better if some recognition to skills I already had could have been included. I thought that less time should be spent at the polytechnic where shared learning with the nurses really was not helpful. It seemed that midwives were expected to fit into the nurse programme and this wasn't useful to me. I was a midwifery student not a nursing one. I felt isolated and wished that more people understood what the pre-registration course was about.

Increasingly I was becoming aware of where the power lay. While I could identify changes I would like to have made it was becoming apparent that nurses at the polytechnic had more control over what happened. I felt midwifery education should be separated from the polytechnic that midwives, teachers and students had little say in what they could do. At the same time there needed to be more staff and student meetings to sort out some of the difficulties I was having. I was struggling to work out what the game was to fit into the hospital hierarchy and find ways of getting by.

One student took notes as we considered recent experiences. There was a lot of stress, anxiety and under confidence around. They described feelings of vulnerability, unsupervised practice and lacking guidance or direction. They felt unsupported by midwife mentors or tutors. The group talked much more freely and commented that at least one of them had said much more than she usually did. They agreed it was easier to talk in a smaller group. They said it was difficult to write things down but easier to discuss them, that as this was confidential it was easier to talk about the problems they were having and good to share these with each other. So writing had been a problem. There was also still a lot of difficulty in identifying issues from "concrete" experiences and there were real difficulties in trying to identify <u>how</u> things could be changed. Instead the group continued to talk about what they wanted to change but seemed unable to think of ways of achieving this.

The main themes from the accounts seemed to be about confidence and skills/knowledge (indicating a task-centred approach to midwifery) and these two issues remained top priority now. Beyond this it was hard to identify/analyse the accounts further. The group didn't feel they had time to write further accounts so a suggestion that we look at a particular topic seemed preferable. It was suggested we consider *working/being in a hospital and/or stress.*

WORKSHOP 4 ***Gaining confidence***

I'm feeling more confident now, though I do occasionally feel that I take one step forward and two backwards. I have gained "hands on experience" and had a chance to "double scrub" a few times. I feel it is important to get the five double scrubs done. I did get all ready to do one and then the delivery went wrong and forceps were used or the third stage went wrong and so I couldn't count that as one of my double scrubs. But I would soon have done five and then I should be able to do a supervised delivery. Being involved in deliveries helped me to feel that I was making progress and if a long time went by without a double scrub I felt that I wasn't having much luck. I had also begun to know what I was feeling for when I did a VE though others in the group found it difficult to ask to do this. Others in my group also had not had the same opportunities to gain these experiences and one asked to spend more time in the delivery suite. A lot depended on where you worked - one of the group had not worked at all in delivery suite. But if you were in the right place at the right time there was a chance to get some practice. If a student was allocated to work in one clinical area they did have a chance to practice specific skills while others who worked with a team of midwives might spend much less time in labour suite practicing for example "double scrubs".

I was also lucky because I had worked more with my mentor, while some of the others didn't see theirs very often. In some cases they weren't even allocated a mentor. But in the new midwifery led unit there was a smaller staff so it was easier for students to work with a mentor. Over the previous three months I had got more used to shift work and the hospital hierarchy and I felt the staff were getting to know me better (though they still didn't seem to know much about the course). At least by then I felt if I didn't know or understand something I could ask questions. My mentor has helped me to fit in and I had got more support as the course had gone on yet others in the group still felt very unsupported. I was becoming familiar with who was who in the hospital and what the rules of the game were.]

JULY 1992 **Constructing accounts**

A student whom I had never met had left the course and it had been decided at the last workshop that I would write to all of the others who had not recently attended asking them whether they wished to continue with the research. I also wrote to the student who had walked out thanking her for coming and reiterating that it was best if she felt unable to participate under the conditions that had been agreed if she no longer came.Eight students were present at this workshop, two had written to me saying they no longer wished to take part in the inquiry and I was told that a third would be writing also to withdraw from the group. Another student (the fourth so far) had left the course so 8/12 of those still on the course were now in the inquiry group.

The students all seemed much more positive that day than last time - talking excitedly about "double scrubbing". Generally there was a feeling of increased confidence - all but one group member said they felt more confident and had learnt a lot. Having confidence they said meant that they were more able to say they didn't know something. The emphasis was very much on achieving practical skills.

An extract from Melia (1987 p13,18-19) which I had sent them, was thought relevant to their experiences. The idea of socialisation and social control were considered useful but, although they acknowledged there are "unwritten rules" about being a midwife, they couldn't identify what they

felt I was learning the proper stuff now and focussed more on the practice issues than the difficulties being raised in relation to the College.

I recognised some features of the hospital influence my experiences. It is almost a self-contained world with its own rules and policies. There was a structure of social relationships between clients (or patients) and staff, and a bureaucratic system for decision making and controlling how the hospital works. Clients are very vulnerable in all this, they have no privacy though some might like to share rooms with other women. Those in authority wear uniforms as a sign of their status. But I had learnt to "play the game" and not to be conspicuous. I had begun to learn how to behave as a midwife, to learn the "unwritten rules" of when to speak and when not to. This was a system of informal control which influenced how I behaved. I didn't constantly feel I was being assessed. I just used to find someone who was willing to sign my assessment form when the time came

The hospital was more familiar now and it provided me with a large range of experiences, there were a lot of different people to learn from and always someone to fall back on. I did get conflicting advice at times but nothing seemed as frightening or intense any more. I thought there were differences between midwives and nurses, that midwives are practitioners in their own right and they don't care for the sick but healthy women who are pregnant but do not have an illness. In this sense it seemed that Melia's account of student nurses might differ from my experience as a student midwife.

I didn't really feel that I fitted in at the polytechnic though (it has become a university) and I didn't know much about the changes that were taking place or how it was organised. Nobody told us students what was happening but I was worried by what was going on. The university seemed to dictate to the midwifery college and midwives had little say. I thought the university wanted to extend the range of courses it offered and that was why it wanted the midwifery course and these changes probably had something to do with

were; with one exception -"When to speak and who to speak to". "Fitting in" was seen as a very important way of getting on in the course. There was little said about challenging or questioning practices only about finding out what they were.

When asked to draw the structure of the organisation they had found this quite difficult. The group knew very little about the poly/university and while some thought about midwifery service organisation they had little notion of a structure, writing only the list of jobs people hold eg. "manager". I told them what I knew about the reorganisation and then immediately wondered whether this was a foolish thing to have done - what kind of information could I legitimately introduce into these group sessions? We agreed to discuss these proposed changes in the next workshop. While they would try to find out more about the new organisation for next time I might look at theory on organisational change.

We discussed how the evaluation could make a difference and although some thought it would not help their situation the idea of writing about their experiences in an article or report and contacting other pre-registration midwifery students was welcomed. I suggested that they think about what they would like to use the inquiry for and we would also discuss this next time.

money. I just hoped my bursary wouldn't be affected as grants are lower than the bursary which do not include unsocial hours payments as it is. I didn't see myself as a university student and I didn't want to be part of a big university. I had got used to being part of a midwifery college and I wanted to feel I could contact a midwife tutor on clinical days if I needed to. Yet as such a small group it seemed that midwives had little say in such a large institution.

Reflections

This was a good point at which to reflect on where the group inquiry had got to so far. I attempted, in my own notes, to identify the key issues with regard to the a) the method and b) the experiences of being a pre-registration midwifery student. Inevitably process and content were intertwined but analytically they could be discussed separately which was my intention in this thesis. It was also useful to discuss each of the two inquiry groups separately since they were quite distinct in a number of ways and certainly my experience of working with each group was different.

In this group I felt much more of a welcome visitor at this July meeting. The eight remaining members seemed keen to continue the inquiry. Meetings appeared to provide a welcome opportunity to reflect on recent events and the group were enthusiastic in their discussion. I still tried to avoid being too directive, but perhaps my role in the group was precisely that - directing the proceedings. They apparently liked it that way. It could be that my role here was to act as a facilitator in their collective effort to construct an account of what was happening to them. The group did not have a worked out account of midwfery when they began but were interested in mothers and babies, helping people etc. The group work appeared to be much more about building and constructing an account. Here I seemed more in control; was this inconsistent with a democratic approach to research?

WORKSHOP 5 A traumatic time

These few months had been a traumatic time as there was a major reorganisation in the college. I still hadn't quite worked out what the new organisation was but I knew that we all came under the university now and there was a nurse in charge. The midwife teachers didn't seem to have the same status as the university lecturers or be on a par with them. Everything had moved away from the hospital and the NHS trust had taken over the old College accommodation. I had to travel a long way to get to the university and I had to pay for this myself. When I got there I couldn't park and although my group argued for parking permits but had a lot of trouble getting them. The health authority buses were hopeless- they didn't run often enough. I was very upset about all this because they had changed all the terms and conditions I accepted when I began the course. I used to get travel payments and now I have to travel further, I get none.

At the university there was no common room or even a kitchen where we could boil a kettle. There were no drinking fountains, cloakrooms to hang your coat or a locker where you could leave your books. Everyone was expected to eat in the refectory so there was nowhere to eat your packed lunch. The facilities were just inadequate and there was no room for us. My group had tried to arrange meetings with staff at the university and discuss these things with the midwife teachers but it had all been rather unpleasant and there had been a breakdown in the relationships between us and the staff. We had been told we were being childish and unprofessional. The midwife teachers didn't seem to be willing to support us at all but then they were probably in fear of reprisals or losing their jobs as some of them had done already. We tried to follow the formal procedures for consultation but the university representatives were hostile and made us feel we were not wanted. We weren't able to join with the nursing students in discussing these changes and were excluded from a meeting they had with their union steward to discuss the changes.

NOVEMBER 1992 A sympathetic listener

The group were quite task oriented both in how they approached the inquiry and, from what they said, I suspected their midwifery care. This meant that we got through the sessions quite efficiently and they were much more easily guided toward thinking about particular topics. They were willing to explore theoretical concepts and this could be because previously they were less clear about their views. Was this why they were more willing to use the group inquiry to construct one? The group was easy to direct and because they were so positive about their gradual integration into midwifery my working relationship with them became more comfortable. It was as though I was witnessing a process of assimilation and as a consequence the group found it hard to see what the difficulties had been earlier in the course.

The idea of group inquiry being a chance to be "listened to" was much less threatening or challenging than to "bring about change". These students were reticent about what could be achieved through the inquiry even though they had welcomed the idea of being able to write something with me and wanted to have contact with other students. Neverthless resistance to the current changes in the college was evident and highlighted their upset at having a rather cosy relationship with the midwifery education department destroyed. The upheaval in the college may have represented a real threat to what had so far been a stressful but

All this made me feel awful- my health suffered and everyone in my group had complained of symptoms of stress- headaches, raised blood pressure and increased asthma attacks. I had felt really depressed and unable to concentrate on my studies which were disrupted. Some of our taught sessions were abandoned because the group were so upset and couldn't concentrate. I still attended some sessions with the nurses but they seemed irrelevant and since our attendance was not monitored I thought about not going any more.

There were some gains. We managed to get our timetable changed so that I only needed to attend the university one day a week rather than two. The other study day I had at our old centre in the hospital which I much preferred. I also got more private study time included in the timetable and a few parking permits for when we do go to the university. As a group our year have come together much more because we've gone through this together.

My experience showed that midwives had lost control of midwifery education as others suggested (Warwick 1992). Midwife teachers had no power or status in higher education and they were losing contact with the service side. The links with service had been weakened as the college had moved away and there were no longer any clinical teachers. It was difficult to contact a midwife teacher now and they seldom got to visit me in the clinical area. It seemed that midwifery could not keep its independence inside higher education. I didn't want to be part of the student union I saw myself as a clinically based student midwife with theoretical input not as a university student with clinical input. I belonged to the RCM and anyway students have no power. As midwives I thought we need to keep our identity as a practical profession and as professionals in our own right. I thought midwives are losing their skills and we need to fight to keep them rather than de-skill ourselves. Nurses do not appreciate what we do and

manageable process and they welcomed the chance to talk to an outsider about these difficulties.

The workshop was to be held in what had previously been the midwifery education department . On the surface little looked different but although the plaque over the door to the department was the same, offices contained different personnel and a door labelled "obstetricians and paediatricians' secretaries" seemed symbolically significant. What was still labelled "common room" looked more like the shell of a classroom as the easy chairs had gone. No-one asked who I was or whether they could help as they walked up and down the corridor past me, while I stood outside a door with a paper sticky label reading DE91 suggesting that the group I was looking for were contained within. After standing here for a while I parked myself in the rather empty "common room" - no-one seemed to care and eventually one of the student group appeared to fill their kettle from the sink there.

The students were friendly and very talkative. Six attended the workshop, two were away. I had a plan for the session but their enthusiasm to relate to me the events of the past 3/4 months rather overtook this although we covered the same topics. They preferred to tell me as a group what had happened rather than identify the effect changes had on them individually. This was because they said the problems had

P2000 saw midwifery as a branch of nursing because they didn't recognise the differences between us. I had met nurses and we are different we have specialist knowledge in one area and in-depth of knowledge the nursing students don't have. I had been accused of thinking I was better than they are but I'm just different. I had far more clinical experience than the P2000 nursing students and I would have more responsibility when I qualify. They don't always appreciate this until they come on a maternity placement. I sometimes got called "nurse" and I always corrected people telling them I am not a nurse but a midwife.

It was difficult to say where I got my ideas about what being midwife means. A lot of people are very "woolly" about midwives and there are different ideas about whether midwives should be nurses first or not. There is some suspicion around about "direct entry" midwives being threatening. What is more clear is the division between midwives and nurses. All midwives in this hospital recently agreed that their uniform should separate them from the nurses. Being a part of the university meant that midwives had lost their identity and my idea of a midwife is more consistent with the view that we should have a separate college with midwife teachers teaching all aspects of the diploma. I don't agree with some of the others in the group that there is anything to be gained from the link with higher education. It just means they set the agenda and make the decisions and midwives are under-represented in that process. Midwives are not equal partners in the decision making. As a student group we don't have much power at all but at least our actions provoked a response and we stood our ground together.

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been shared and they had acted collectively in trying to deal with them.

The group were less clear about the form of the new university structure than I had expected and only tentatively were able to list the staff changes. It was difficult to help them stand back from these experiences, to examine why this had all happened or to generalise from the specific problems they described. Perhaps this was because it was so recent and they had had little chance to reflect on everything. One did say that I was the first person they had discussed it all with since it began. There was a general feeling that now things were settling down, and that some of their requests had been met .

We discussed the article by Warwick (1992) on changes in midwifery education - it had limited use as a tool for explaining some of what had happened and they did not identify with it as readily as I had expected. Perhaps this was because it was written from the perspective of a midwife teacher?

The timetable and content of future meetings was agreed and one student said she looked forward to reading my PhD!

WORKSHOP 6 Developing practical skills

After eighteen months on the course I had gained a lot of practical experience on placement in the community, antenatal, postnatal, labour and paediatric wards. In my group students had placements at one of three hospital sites and this affected the kind of experience each of us had because the organisation of care was different at each hospital.

I saw mostly high risk women in this hospital. I worked in large hospital teams which care for women during antenatal, labour and postnatal stages. However I didn't really have the chance to follow a woman throughout her care and if I saw her in the antenatal clinic I was unlikely to meet her again. The wards were mixed antenatal/postnatal and each of the four consultants had a ward covered by a midwife team. There was more continuity between caring for a woman during labour and postnatally but because I spent so few days (2-3) each week in the placement this was limited. In future smaller teams may improve the continuity of care. Other students had placements in a small midwifery-led unit for 'low risk' women at another hospital. While at the third hospital they were allocated to work in a particular area (eg. postnatal ward) for the duration of the placement moving to another area for the next one. We would all have liked the chance to move between hospitals for a period during our training to see what each had to offer and the different ways of organising midwifery care. All the hospitals now have trust status.

I enjoyed the placement if there was plenty to do and a variety of things to get involved with. If I ended up doing repetitive tasks (as in the antenatal clinic) or if the placement hadn't been well organised (eg paediatrics) I got frustrated and bored because no-one seemed to know why I was there or what I should have been doing. The community placement was enjoyable to begin with but became more routine as time passed. I had mixed feelings about the antenatal clinic as it could get very repetitive Most of the group

FEBRUARY 1993 Keeping a critical distance

I decided to travel by train since there had been a lot of fog around. This meant leaving at six in the morning in order to arrive for a 10 o'clock workshop. Friday was the day that the students spent in the classroom at the hospital site (a special arrangement they negotiated with the university after the recent changes). It was coffee time when I arrived and I was invited by the tutor to have coffee with them in the office. I always felt rather uncomfortable about this since being with the staff seemed to automatically distance me from the group I had come to see. However on this occasion I was to interview the tutor after the workshop.

All eight students attended the workshop and they all seemed relaxed and more cheerful than on my last visit. When asked what they had thought of the feedback from that workshop, one said it was "quite tame" and another said she enjoyed reading it. The topic for this session was the practice placements.

Since there were three sites used for placements I asked someone from each site to briefly outline the way care was organised there. This was to put their experiences in context. There were significant differences between the sites which include a small 17 bedded unit, a larger "high tech" unit where midwives were organised into four large teams each attached to a consultant, and a unit where care

didn't like being in clinic. Having a good mentor made a lot of difference and if I could work with my mentor frequently I felt I was progressing and gaining confidence. The visits with the health visitor and social worker were interesting but the day at the family centre was a waste of time because no-one knew what to do with me. Working in the delivery suite was not as good as I had hoped. A friend of mine became really stressed about her long allocation there. As with the other placements the person you worked with on delivery made a big difference to the quality of the experience.

I saw the role of the midwife as a carer, educator, counsellor, communicator, skilled, responsible and competent in all areas (pre-conception onwards) and this was what I was working towards. I didn't felt that not having nursing experience was a disadvantage though on occasions when a woman was ill I noticed that a qualified nurse was allocated to her. Though I was learning some nursing skills I didn't think others believed that pre-registration midwives were capable of caring for ill people. On placement in non-midwifery areas pre-registration students were not even expected to take a blood pressure! Yet midwives do have these skills and many others.

Midwives have knowledge of pregnancy and being able to recognise the normal and abnormal. Unlike doctors who see pregnancy as normal only in retrospect, for midwives it is normal. We are better than nurses at taking a woman's history on booking we have the skills to do vaginal examinations, deliver a baby, care for a baby, help with breastfeeding, educate and advise women, remove clips and sutures using aseptic technique and other skills too numerous to mention. Learning this takes practice and is assisted by mentors having confidence in my ability. It was sometimes confusing when I got conflicting advice but in time I would be able to make up my own mind about what to do.

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was split and staff worked either in antenatal, delivery or postnatal wards. I got the feeling that the group were now very aware of these differences and often discussed them. It was useful for me to be reminded of them.

The students appeared to really enjoy drawing pictures of their placement experiences and there was a lot of laughter and chat about it. The variety of representations was fascinating and this exercise did help to focus the session on the placements. It also helped to highlight the time that had passed since group inquiry began. One student said it was a pity we weren't going to meet to discuss the nursing placements which would be later in the year. But I replied there might be some opportunity at the end of the course to reflect on those?.

The students were very chatty and at one point I felt the session becoming too relaxed. This I considered a problem only in so far as they did not then distance themselves from their subjective accounts. It was difficult then to develop a critical analysis of these accounts as they enthusiastically told stories of their experiences (without generating explanations of them). They were uncertain whether the role of the midwife might be changed by pre-registration midwifery education. Surprisingly they were hesitant in listing the skills a midwife needs and identified only one factor which influenced learning- the staff they worked with. The article by Kargar (1990) on

There has been a decline in the opportunities for students to learn "traditional midwifery skills" as Kargar (1990) suggests. I worked in an hospital where a lot of technology was used and I had to learn to work with it. Commonly monitoring equipment was used rather than a Pinard stethoscope and in some cases it was argued that for example by using a sonic aid the mother benefits because she could listen to the foetal heartbeat. Again the views of the midwife you work alongside can be very instrumental in determining the kind of care a woman is offered and the learning opportunities students have. I recognised that there are different views about what midwives should do and in this hospital much of what went on distressed me. There was not always a consistent or continuous approach to care and that also caused me difficulties. There was a lot of involvement in care by doctors here though of course it was different again in the midwifery led unit. If I could have changed anything about my placements it would have been the chance to see more 'normal' deliveries, and time to work in the midwifery led unit where I could have perhaps learnt more 'traditional midwifery skills' like using a Pinard. I would also have rather spent more time in one place and moved around less. Others in my group would have liked to have gone to this hospital, had nursing placements earlier in the course so that we could have learnt those basic nursing skills sooner and spent more time in the clinical area, less in the classroom. Looking back I could see the distance I had travelled on the course, looking ahead qualifying still seems a long way off and will there be a job for me?

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traditional midwifery skills did give pause for thought and returned the conversation to differences between the sites. Clearly there were students who were very dissatisfied with the placements. I asked them to consider their experience of these contradictions and competing views of midwifery practice/care and the influence of technology in midwifery. Yet to introduce some kind of formal, theoretical explanation of ideological processes seemed inappropriate. Again I felt acutely the problems of confronting them with alternatives to their everyday accounts, asking them to deconstruct those using the conceptual tools of sociological explanation. This dilemma about the relevance or value of formal theory as a critical tool for empowering participants remained an important issue to discuss in my thesis.

We agreed to use the outline of a 'Writing a group inquiry report' (see appendix 14) to structure the next meeting. I acknowledged that this would involve some work to prepare for that session and the copies of earlier feedback were welcomed. (I suggested that they might be useful if their copies had ended up in the bin and from the reaction this received some probably had!!) I would send feedback from this workshop as soon as possible together with a copy of the article by Kargar (1990).

WORKSHOP 7:MAY 1993 -Writing a report on Group Inquiry 1

A collective process

The final workshop took place in the university - the first time I had met the group there which of itself illustrated the change that had taken place - it was official that they were university students. I found the group in the allotted classroom and they waved me in, apparently pleased to see me. We re-organised the room so that we had a conference table to work on. Seven students were present (one was sick).

Having already asked the groups to prepare for this workshop using the pro forma (appendix 14), I decided it might be prudent to have a go myself. This task proved quite difficult and I was anxious about how the groups would manage it or indeed whether they would do it at all.

I had also wondered whether to tape this meeting - was it another workshop of the same status as the others or somehow different, the ending? This ambiguity reflected the absence of a clear separation between data collection and analysis in group inquiry. All along these had taken place in tandem so this workshop, like the others, was data and analysis. I decided therefore to record it as I had done previously.

All but one in the group had managed to complete the "writing a group inquiry report" proforma which I had given them. I was pleasantly surprised by this having prepared myself for them not having done it at all. I thought when I looked at it myself it was not an easy task and I had been feeling quite anxious about the meeting.

To begin I restated the purpose of the meeting and asked the group whether they would like to co-present a paper at a conference, or co-author an art'cle for publication. In pointing out that group inquiry sought to share aspects of the research process I asked them how far they would like to be involved in the report stage. This was met with a mixed response. The idea of attending a conference seemed scary to them and no-one was very keen to stand up and speak in public. I explained that co-presenting or co-authoring a paper meant revealing their identity therefore everyone in the group needed to agree to go ahead with that. There were a range of views about this. One student explained that she had been able to talk freely because it had been confidential and did not now want to put her name to it. At least one other felt the same way saying that they still had to finish the course and then they would be applying for a job. Two of the group were very comfortable with being identified and would like to do that. Since there was no unanimous agreement I suggested that we could write the report and then re-open the discussion about revealing their identity when they had thought about it some more. I explained that it would also be necessary to get the consent of the midwifery department for them, since by revealing their identity the department would be implicated. This was agreed and although those that wanted to put their name to the report felt no difficulties would result, they were quite willing to respect the wishes of others in the group.

We then began to work through the feedback for each workshop and discussed what important points needed to be included in the report.The student who had not looked at the feedback or completed the form contributed to the discussion by checking the material for each workshop as we went along reminding us all what had been covered or the date of the meeting etc.

As the discussion progressed I realised that this session was like a "debriefing" as it gave everyone, (especially me) a chance to reflect on how the inquiry had gone. I asked what we might have done differently, whether it would have been better if they had been given more or different information. Evidently writing about "significant events" had been seen as too difficult and much more of a drama than intended. To some of them it had seemed like a request to write an essay which they felt unable to do at that time. Otherwise I thought they had understood much more about the aims and purpose of the inquiry than perhaps I had given them credit for (how patronising of me). It was gratifying to hear one person say that while midwifery education was based on the idea of the "reflective practitioner" the only real chance they had to reflect on their practice had been in the inquiry group. They had valued the experience and found it had provided them with someone who would listen to them when others would not. So had the inquiry defused conflict for them by acting as "group therapy"- a term used by one of them? Or had the group gained support which had enabled them to identify, deal with and tackle problems in a way they would not have otherwise done? According to the notes of another group member the latter seemed to be the case . This raised interesting questions - did participatory research lead to the researchers being co-opted or empowered? It could be that by providing a vehicle, that is through the taking part in the inquiry, participants did not explore other ways of taking action about the issues that were of concern to them. This made the report stage even more important for it constituted a form of action which resulted from the inquiry and had value in so far as it was taken seriously by others as a legitimate and valid knowledge claim.

I enjoyed the session and they did too. They told me they had enjoyed taking part in the inquiry. When asked if they would have done it had it not been timetabled they mostly said no - they just would not have had time to give to it. They did however realise that it was entirely voluntary - they could have chosen not to continue. When I asked if it had made a difference to the other students in their year they replied that those students were not interested in the research and instead looked upon those timetabled slots as their 'free time'. The seven students in the group expressed feelings of solidarity, and shared experience which they felt very positive about. They also made comments how they were different from other student years and they reflected on how their shared upset about the changes in the college had brought them closer together. They talked a lot about how being in a small group was comfortable and they had become more at ease with each other as time passed which also meant they could disagree. Perhaps this was an indication that group inquiry did not after all create an overwhelming pressure for consensus, that diversity was also permitted. Certainly they indicated that they had all been able to say what they wanted to.

The group were on placements in the nursing areas and it seemed a pity that we would have no opportunity to discuss these. If the chance to meet up again the following year was feasible I was sure it would be worthwhile to conclude their accounts of being a student when they were due to qualify.

We briefly discussed the case site visit in June, to report back on the evaluation project. I re-iterated that group inquiry would not be reported on in any detail at that visit since it might place them in a difficult situation, but some general conclusions may be included. We agreed that I would send them a draft of the group inquiry report for them to comment on and at that point we could decide whether another meeting was necessary. I would also return their "writing a group inquiry report" forms so that they could use them to check I had included their key points.

AUGUST 1993 - Postscript

All group members were sent a copy of the draft report on group inquiry and invited to comment. Only one person replied by letter and I telephoned two others to check they had recieved the report and find out whether I should go ahead. They both told me that it was fine and they had not written because they had nothing to add. They were busy coping with the daily struggles of the course and had other things on their minds.....

CONCLUSIONS

This concluding section underlines the issues and questions that are contained in the account of becoming a midwife and the story of the inquiry process.

CONTENT

In summary the students began the course with a health focus, wanting to care for women and develop a career that was women-centred. They emphasised the importance of practical skills at an early stage and their anxiety, stress and uncertainty were expressed in terms of an inability to do certain things. Their confidence and the development of practical skills were closely linked as, over time they gained experience in different placements and had the opportunity to learn these skills. This emphasis on practical skills suggested a rather task-oriented approach to midwifery and a prioritising of practical knowledge over theoretical knowledge. Their concern to fit into the hospital system indicated a willingness to conform rather than question or challenge existing practices.

Increasingly they enjoyed being in the practice settings though there were considerable differences between the three hospital sites where they worked. This significantly shaped the kind of placement so, for example, where a student worked in a midwifery-led unit she had become more integrated into the midwifery team and was also able to work with the same woman through the stages of her pregnancy (giving greater continuity of care). In contrast, others in the group were frustrated by the fragmentation of care in the hospital and their learning experience in separate parts of the system (eg. antenatal clinic, labour ward, postnatal ward).

While all the students were initially critical of the lack of support from tutors and mentors[1] some continued to feel unsupported throughout, while for others, as they came to know the staff, they felt more satisfied. As the students progressed they became assimilated into the hospital and identified more strongly with other midwives. Initially staff had been unfamiliar with the pre-registration route, and while some students in the group came to feel

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[1] Student midwives work with a midwife mentor in the placement who has a responsibility to teach, supervise, support and assess the students (ENB 1991, 1993). See Kent et al (1994).

accepted others remained convinced that the staff were unwilling to accept or help them. Again this variation could be partly explained by the difference between the hospitals where the students worked.[2]

From an early stage the students expressed antipathy and dislike of being at the polytechnic. In their view the shared lectures with nurses were inappropriate and irrelevant. This negative view became strengthened over the eighteeen months especially as they became more accepted by other midwifery professionals. They were becoming increasingly distant from the polytechnic when the College of Midwifery and Nursing was dissolved and integrated into higher education. The group's resistance to these changes and strong criticisms of them could be seen as a conservative response but to them it represented a threat to their identity as midwives and signalled a loss of midwifery control over their education. As a consequence they felt powerless and let down but the experience drew them closer together.

To the students it seemed that midwives had become weak, that they needed to assert themselves as a practice-based profession. In the educational context nurses appeared to control them but the students emphasised their distinctiveness from nurses and the right of midwives to manage themselves. At the same time, in the practice areas, midwives were seen as losing 'traditional skills' and although the students saw pregnancy and childbirth as a normal process they seldom participated in what could be called a normal birth. This they found disappointing but they remained committed to completing the course and looked forward to the day they would qualify.

This group were not explicitly 'feminist' in their outlook but their view of midwifery placed value on what is commonly seen as women's work - caring, health promotion, practical skills and working with babies and mothers. For them, to make childbirth a happy and fulfilling experience was their principal aim. Their personal ambitions were important but mostly they wanted to do what was best for 'others'.

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[2] In a later telephone coversation (Autumn 1994) one of these students described how this lack of acceptance had continued over the three years. She felt it was both because they were pre-registration students (and therefore had no nursing experience) and because they were older women and mothers and therefore quite different from post-registration midwifery students.

PROCESS

The story of the inquiry process raised a number of issues. First relating to membership of the group, there was an initial concern that students might feel pressured to take part since the workshops were timetabled and held on College days. However, after the initial workshop, since between seven and ten students attended, this indicated that the voluntary nature of participation in the inquiry was understood. Related to this, the size of the group was not a problem because four students left the course and three withdrew from the inquiry. They did not give their reasons for leaving but the fourth student to exit the inquiry was encouraged to do so. Her unwillingness to comply with the agreed terms of participation may be seen as indicative of a procedure that was far from democratic. For in asserting a view that participants, having agreed to be tape recorded and to contribute by writing notes, accounts and in other ways, this person was actively excluded from the inquiry. Neither was there a will to try to accommodate her. This raises important issues about the model of democracy that could be applied to this inquiry. For by adopting a majoritarian procedure, in this instance dissenters were excluded. As a result the account of becoming a midwife produced and represented in this chapter could be seen as silencing 'other others'. The difference of opinion about the process whereby the account was to be produced was not examined further and the resolution of this, by the student exiting the group, was in many ways unsatisfactory. While later the group expressed solidarity and said they had become more comfortable with each other and able to disagree, this earlier disagreement demonstrated that certain differences would not be tolerated. In effect the dissident student violated the central premise on which group inquiry was set up - that participants would be willing to enter a dialogue and contribute to discussions that would work towards reaching agreement. By refusing to share her views with the others, more than the issue of what kind of records were kept, this student appeared to reject this premise. Moreover her suggestion that she might take notes while others discussed what they thought was deemed unacceptable for it set her apart from them. So is consensus 'good' or 'bad' i.e morally justifiable? Does it elide difference and obscure conflict? Is consensus "ideological"? These questions and the extent to which there could be unity in diversity are important and I shall explore them further in chapter six.

Differences did remain within the group and I was different from the others because I was not a student midwife and had a nursing background. My

role in the group and the concerns I had about the kind of contribution I made - whether it was right to introduce sociological concepts and theories, or talk about information I had obtained in relation to other activity for the evaluation project, highlighted this difference. This in turn raised questions about what it could mean to be 'co-researchers'.

Another theme running through the story of the inquiry was the relationship between theory and experience. Did the subjective experiences of the students provide a foundation for knowledge and was it important that they distance themselves in some way from this in order to analyse critically what they said and what they wrote. While Reason (1988) had talked of "critical subjectivity" the means by which we may become critical of everyday experiences was not clear. In their study using 'memory-work', Haug et al (1987) had written about their memories in a group, and the process of writing was itself regarded as a critical tool, a means of resistance, a way of rewriting history. Yet in this inquiry writing had been a problem. The students had difficulty in writing about 'significant events' and preferred not to continue writing accounts (workshop 3) but to talk about their experiences instead. This they found helpful and "therapeutic" and though the intention was not to have some kind of 'group therapy' seeing me as a sympathetic listener and feeling that the inquiry gave them a space where they could reflect on their midwifery practice was felt to be beneficial. The function of the inquiry to be heard, or listened to, was valued more highly than the idea that its purpose was to bring about change or to analyse their experiences. Yet did such a view undervalue the potential of writing and talking and listening as forms of collective action? Was the inquiry empowering or had the group been co-opted by a mechanism that enabled them to speak and be heard but which would have little impact on midwifery education? Or did such a view fail to recognise individual changes - the ways in which their identities as midwives were actively (re) constructed through this dialogical process? These questions will also be examined in chapter six and will return to debates within feminism about the reification of experience and how 'experience' is discursively constructed. It also raises questions about the emancipatory claims made by participatory researchers such as Maguire (1987) above.

Related to the problems of representation identified in chapter two, in the process of drafting the report further issues came up.The question of style- should the first person 'I' be used in the account of becoming a midwife

since it did not represent a single author but a fictional student who was created by the group? Co-authorship with the students in the group was what I saw as the logical extension of the participatory approach but would it be unwise for them to disclose their names? While I had focussed on the production of the report it was important to also consider the readership (consumption). If the conditions for producing the research report could be seen as 'democratic' how would social relations outside the immediate group mediate the outcome?. What responsibility as the inititating researcher did I have in this respect? Had I exposed a vulnerable group? The inquiry itself and the process of writing the report had raised many questions . Though the workshops provided an opportunity to analyse feedback, identify key themes that arose and write the group inquiry report, it became evident that there was another level of analysis needed to fulfill the objectives of this thesis. In part three, chapters five and six therefore take up the issues raised in both groups and examine them in the light of the debates introduced in part one. But first, chapter four focuses on Group inquiry 2 which took place over the same period.

CHAPTER 4

GROUP INQUIRY 2
"Working With Women"

Introduction

This chapter, like the previous one, reports on the work of an inquiry group by giving an account, in the CONTENT section, of what it was like to be a student on this diploma course at a second case study site. I also present a story of the inquiry PROCESS in the form of a research diary. The two groups were independent of each other though the workshops ran in parallel, over the same period of eighteen months, from October 1991 until May 1993. An overview of this diploma programme and the workshop timetable is given below in table 2. First I shall introduce the participants of this group with reference to the personal profiles they provided for the evaluation project. The chapter concludes with a summary of the central issues running through both the CONTENT and PROCESS sections. These issues, together with those already identified in the previous chapter, will then be discussed more fully in chapters five and six.

There were twelve students enrolled on this diploma programme and all agreed to take part in the inquiry, though one of them left the course, and the inquiry after the second workshop in January 1992. Another student left the inquiry after failing the first year and being required to retake it. Of the twelve, only ten provided personal and biographical details.

All the students were women, ranging in age from eighteen to forty five years old, though of these only three were below twenty five. Three (30%) had no dependent children but the remainder had one or more. One student had less than the UKCC minimum requirements of five GCSE's (or equivalent), and one had sat the DC entrance test. Four (40%) had also written an essay on the interview day for admission to the course. Eight (80%) of the respondents had A'levels (or equivalent) and five (50%) had a first degree in diverse subjects - Oriental studies with Chinese, Geography, Biochemistry and Physiology, History, and Theology. The overall high level of previous qualifications was remarkable for students now on a

diploma programme and indicated that for many of them entry into midwifery was either a career change or a vocational qualification that added to previous academic qualifications, though two students (20%) already had other professional qualifications. Nine (90%) students were white, including a Dutch woman, and another was Portuguese Sikh. Many of them had come from previous employment as, for example- a joiner, laboratory technician, travel consultant, social worker, office supervisor, theatre technician, part-time care assistant and local authority advisor. While the remainder had previously been at college or school.[1]

The diploma programme is three years in length and the curriculum documents provided an overview of the organisation of the students' education. They too had their time divided between college and the clinical areas. They usually had taught sessions in the midwifery department, in the hospital, close to the clinical areas where they worked. Lecturers from the polytechnic came to teach them there, so seldom were they required to visit the polytechnic site some miles away. They were taught as a small group and had no contact with other students at the polytechnic. There were limited opportunities to meet other midwifery students at the hospital.

The aim for the first year was to focus on 'normal midwifery' in both community and hospital settings. Students were assigned two 'link midwives' in each setting, qualified staff members who were expected to work closely in a supportive way with the student and assess them. Team midwifery was being introduced in the hospital but had initially been consultant led rather than significantly altering the organisation or delivery of midwifery care. It was a time of great upheaval and transition in both the clinical areas and education. The hospital became an NHS trust in 1991 and the College of Health Studies was newly formed at the same time the pre-registration midwifery programme was being developed. The effects of these changes are discussed more fully in Kent et al (1994).

The second year of the programme centred on normal and abnormal midwifery with an introduction to paediatric and surgical care in both hospital and community settings. While during the third year, after the inquiry was completed, students would spend time in medical and psychiatric areas before returning to midwifery practice and qualifying in

1 For a more detailed discussion of recruitment and selection to pre-registration midiwifery programmes nationwide, see Kent et al 1994.

October 1994. Each year was divided into four terms of 10-14 weeks. Weeks were identified as either theory (in college), clinical practice (in hospital and community) or a split week with a proportion of time on theory and practice. The proportion varied as the student progressed. Following evaluation by the first student cohort in 1990 this pattern was altered to avoid fragmentation so that study days were usually taken as a block of four/five days. In addition a number of weeks throughout the course were set aside for self-directed, individual study.

TABLE 2: Overview of diploma programme and Group inquiry 2

Date	Diploma Programme	Group Inquiry 2
1991 September	A three week introductory block in college followed by practice in the community	
October	Time split between college and community placement	Introductory workshop: *A chance to work with women.*
1992 January	First hospital ward allocation with study days	Workshop 2: *The politics of midwifery*
April	Study block week, annual leave and a week of self-directed study.	Workshop 3: *Working for change*
May	Group allocated second hospital placement or in the community with study days	
June		Workshop 4: *Philosophy of care- a midwifery model*
November`	Hospital based placement continues with study days	Workshop 5: *The context of care*
1993 January	Placements in the special care baby unit and paediatrics commence with study days	

March		Workshop 6: *Midwives are not nurses*
April/May	Return to midwifery placements in hospital, with study days	Workshop7: *Writing a group inquiry report 2*
July	Placements in general surgical wards (nursing areas) begin. Followed by medical and psychiatric nursing. Returning to midwifery towards the end of their third and final year. (Detailed information of the placement pattern was not available at the time of the inquiry).	
1994 October	Students qualify	Follow-up letter (appendix8)

As in previous chapter, what follows is an account of what it was like being a student on this second diploma course. The CONTENT section was co-authored by the group following the seven workshops. At each workshop the group decided on certain aspects of their experience to discuss or a particular issue that had been important to them (see workshop plans in appendix 18). In addition to a tape recording of the workshop, notes were taken and feedback sent to everyone who took part. In the final workshop this material was reviewed and analysed in order to reach an agreement about what should be included in the report. A fictitious student was created to represent the groups' view so the "I" is this section does not refer to any particular individual but rather a fictional character. There were sometimes diverse opinions within the group and these are indicated with reference to "others" though more often a synthesis has been achieved which includes the experiences of different individuals.

The PROCESS section is presented in the form of a 'research diary' and time is an organising principle for this story of the inquiry process. As

before I draw on fieldnotes, feedback sheets, the tape recordings and the discussions in the final workshop to create a 'diary' which provides an opportunity to draw attention to what were key issues related to group inquiry method. For by telling this story of doing the research I will be able to identify theoretical and practical problems that arose. As in the previous PROCESS section, the "I" here represents myself as both researcher and author of this story. A separate story of the inquiry process was co-produced with the student group and may be found in the evaluation report (Kent et al 1994) and in appendix 16 of this thesis. Both the section above on CONTENT and this one on PROCESS present a first level analysis of data which is summarised at the end of the chapter but which will be elaborated in chapters five and six respectively.

WORKSHOP 1 ***A chance to work with women***

I became a student midwife because I wanted to work with women and had an interest in women's health. I wanted to help women feel more powerful and to have more choice in the kind of maternity care available to them/us. I wanted to be able to make a difference to other people's lives and have some influence. I hoped to change the system. I saw this course as providing me with an opportunity. I could become a professional practitioner, have a portable, international qualification and a respectable career. I had career ambitions and hoped to be able to rise up the ladder without being blocked by men. As a pre-registration midwife I would be part of a caring profession and part of a historical progression and change within in the profession - the development of pre-registration midwifery.

Becoming a midwife meant many things to me and the other students in the group. I expected that over the three years I would experience a process of personal growth - growing confidence and assertiveness and an increase in my self esteem. Being a midwife seemed to give some kind of status to the duties performed by women. I felt it would give me credibility and status within my family and amongst friends and in addition I would be more highly valued in society. At the same time the job would enable me to gain recognition for skills I already had and validate my previous experiences. It would be a means to self-fulfilment , I envisaged becoming a midwife as empowering for me and a means of empowering other women. As a midwife I would be a resource for others, a skilled, knowledgeable, competent practitioner who would be trusted and be able to help others. This would in turn mean getting very close to women, and working for change with them. I saw job satisfaction and a sense of achievement at having done a good days work as part of "becoming a midwife" . At the same time I expected battles lay ahead as I became increasingly aware of the issues and controversies concerning midwifery and the politics of change.

OCTOBER 1991 **Seeking volunteers**

Access to the College had been agreed in May with teaching staff but despite my earlier letter explaining group inquiry and seeking volunteers to participate, when I met a tutor on arrival in October, she had told the group they had to take part in the research. I was therefore keen to emphasise to them, the voluntary nature of their participation in the research.

After a short presentation about the evaluation project and the idea of group inquiry the group asked many questions about the ownership and control of the MRA project and group inquiry. They wanted to clarify the aims of the research and how it would be carried out. I felt freer to explore this with them since from their questions it seemed we shared the same value base.All twelve students agreed to take part though they were cautious about what it meant to have an "official mouthpiece" for grievances about the course.

A radical group

Given the philosophy of midwifery at this site I considered how the particular context of this group was significant. They appeared as radical, outspoken, mature students, wanting to bring about change, empower themselves and other women, wanting to sort the world out. Perhaps this would be reflected in their groupwork? They appeared cohesive, with a strong group identity. Individuals talked with certainty about "we".

One respect in which things had immediately changed for me was my low financial status and the realisation that I was facing relative poverty for the next three years. But the best thing about being on the course was I felt I was with a group of like-minded people- the other students, and I had enjoyed meeting them, getting to know them and being in a supportive group of others who also wanted to be midwives. I was excited about being on the course, getting back to study and working with women.

On the other hand, early on I thought many of the midwives I had met either knew very little about the course or were rather negative about it. Even the students from last year seemed very negative and I felt that my enthusiasm was dampened by others in the profession and the controversy about midwifery. The course organisation seemed problematic to me and it was difficult not knowing hospital policies.

Their vocabulary included "power, politics, empowering, enabling, the system, personal growth and development, feminism." These words reflected a level of awareness of conflict and oppression which I felt did not surface in the other group. But this group expressed a lot of anger which could become destructive in the inquiry and I felt anxious to avoid it being directed at me!! I also wondered whether the strongly expressed positive feelings of being in a group of likeminded people might give way to competition in future?

The potential for negotiation within the group was discussed. I explained that negotiation would be possible but there were boundaries to the meetings since they had to relate to the research question. My fear was that the group meetings might not progress - I felt confident that they would freely talk about their experiences but there might be a need to control the discussion so that we developed analyses of it. (The tutors had described students as being inflexible and uncritical of their radical views.)

I considered (in supervision) whether the values of equality and democracy necessarily meant that the students would be committed to resolving any difficulties in the group process. I also wanted to clarify to the group that the meetings were not intended as therapy.

WORKSHOP 2 ***The politics of midwifery***

In discussion with the other students I recognised that the reasons for coming on the course could be grouped under four main categories. Essentially these related to career ambitions; affirming and empowering women (myself and others); change- on both an individual and broader level; and job satisfaction. Becoming a midwife was similarly related to job satisfaction; professional status; self-development; and increased status in society. It includes personal sacrifice and learning but most importantly being with women. There was a widespread agreement in the group though some of these themes were more important to me than to others and there was a wider range of views about the importance of career ambition, and improved status in society.

I had already completed a placement in the community and was then getting my first experience of midwifery in the hospital. Already I felt that my expectations and the 'reality' of the midwifery care I witnessed were at odds. I kept trying to remember that my job was to be "with woman" but I wondered whether I was being too idealistic? It seemed that there was a real contrast between the 'normal' delivery and the medical involvement and management in other cases. I was feeling disappointed, angry, frustrated and disillusioned on discovering how women were often treated and the way qualified midwives behaved. There seemed to be no communication between staff and women, no team work and I thought to myself I hope I don't turn out like that. But would the system change me and the other students on the course?.

I talked about something which had happened to me and which I later wrote about in detail:

JANUARY 1992 **- Working together**

At this second workshop the atmosphere was informal. Eleven members of the group were present. We had been allocated a larger classroom, as I had requested, which hopefully would also be less noisy. The group sat in a circle at small tables and suggested I sat at the front where the teacher sits. One student commented that "you are the teacher".

As the groupwork proceeded it became obvious that many had not prepared well for the session. They had looked at the feedback sheets and given it some thought but only a few had come with a written account of a significant event. They seemed willing to share in the research process become actively involved but they were ambivalent about committing time to it.As the session progressed my role was to enable conclusions to be reached so that we might write something down or to summarise, reflecting back to the group what was being said - a facilitative mode?

The identification of themes from the feedback sheets seemed relatively straightforward and there was no difficulty in recognising the similarities between what people said. We were able to reach agreement though there was some dissent as one person said "well status is not at all important to me".Although cohesive,they did not share the same views of all that we discussed but their relationship with each other allowed them to disagree. There was a sense in which they were willing and keen, to debate, negotiate what was

In the public eye
"Place: A delivery room about 5 mins before the birth of a baby.
Those present: Mother, father, midwife and student midwife. (This had been the situation for some time before.)

A second midwife (and student) were called to assist the first midwife at the birth of the baby. The mother was quite distressed, in much pain, screaming loudly, bearing down with contractions. The labour had apparently been long and painful (the mother's first child had been born by caesarian section), the father was completely exhausted and unable to give much assistance. The midwife was more concerned with the fact that the mother was making a noise than with her emotional well-being. The student was reassuring etc.

The second midwife and student entered, waiting for the birth in order to attend to the mother. The baby's head was born a few minutes later. This was achieved after an episiotomy was performed. However, just as the midwife was about to perform this procedure, the door was opened and a consultant obstetrician entered - stood for a few moments assessing the situation, peered between the mother's legs, and left. She was present for no longer than two minutes.

The rest of the delivery was completed - the second midwife and student attended to the baby - and left. They were present for no longer than 10 minutes.

I was the student with the second midwife. This incident has stayed with me - I felt that that mother herself had become invisible! Nobody asked to come in, or knocked and waited for an answer. Most of the qualified staff involved were concerned with their colleagues' actions e.g. the midwife was worried that she would be reprimanded for 'allowing' the mother to make such a noise. Nobody seemed to acknowledge her.

happening to them and the meaning of it. This was illustrated by a discussion of the word "empowering" which was seen as having "nasty connotations", being "feminist", "difficult to handle" and "taboo". A lengthy discussion about the alternative words followed - "affirming" or "supporting" did not seem satisfactory because they were not inclusive enough. The idea of empowering women included the students themselves as well as clients and other women. The group did seek a consensus and finally a compromise was agreed -affirming/empowering were both used. This reminded me of the work by Haug et al (1987) which described the difficulties of language - the absence of an alternative language to describe the experiences of the group as women.

I reflected on why so few had written the accounts? Writing in the third person was seen by some as being difficult. So the groupwork became the means of motivating them to write and help them to understand why and how to do it. At the end they agreed to write about the event they had discussed and send me an account by an agreed date.

There was a lot of anger expressed by the group about the way women were treated, illustrated by the examples they gave of significant events. This was attributed to "the system" and the fact that these midwives are also nurses. There was concern about what might happen to them as they continued the course - would they be changed perhaps even become like the midwives they criticised? Awareness of

In the space of 10 minutes, at a crucial time in her labour, this mother was, instead of being the most important person present, practically ignored or regarded as an inconvenience.

The incident has made me even more determined that I will make sure my allegiance is to the women and not the staff."

Others in the group wrote accounts and many of the issues raised were the same. A central issue was the power relations between doctors and midwives and the ability of midwives to deliver the kind of care women might want.

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conflict between midwives, doctors and the interests of women was evident but an understanding or explanation of that conflict was unformed. Reactions to this seemed varied - some seemed to be preparing to do battle, others considering leaving or opting out. There clearly were differences within the group but despite differences of experience and explanations there seemed a shared understanding of the aims of midwifery - to work with women, to enhance women's choice and control in childbirth. This was surely one model of midwifery?

It did seem that I might lose control of what was happening in the group for they sometimes appeared to divert from the task in hand. This perhaps indicated the rather different agenda I had for being in the group - to do the research; whereas the others were happy to spend the time in discussion without recording it. Their priority was perhaps to make sense of things as they happened, with less concern about how that might be theorised or explained to others outside the immediate situation. It was almost as though in the heat of the moment and the enjoyment of the discussion they had forgotten they were doing "group inquiry". P erhaps after all that was being left to me to sort out? Was their participation more at the level of producing the data?

WORKSHOP 3 ***Working for change***

There were positive and negative aspects of my experiences. As a student I was very conscious of staffing issues- there seemed to be a shortage of staff and a lack of continuous contact with any staff members. I seldom worked with the same link midwife. Instead I was working alongside many different people. I concluded that the link midwife system just did not work though one of the other students in the group had worked quite a lot with her link midwife and another was of the view that although she had seen her link midwife more, it had not been of benefit because the teaching quality depended on that individual midwife (personality). I felt used as "a pair of hands" because the unit was so under resourced and I hated working early shifts!

I had spent a lot of time in the practice areas but it hadn't always been useful. Often the staff didn't know what I should be doing there and I had to plan my own objectives for the placement. They didn't even seem clear about the assessment form or what level I was at. Others in my group felt they spent too long in the same area and had not had a varied experience but each of us had done different things. I was gaining in confidence and in some cases I thought the midwives had more respect for pre-registration students. I enjoyed some aspects of the placements but a lot of these experiences were negative and highlighted differences between what we were taught to expect in school and what happened in practice. In particular I wanted to see more "normal midwifery".

Contrasting our recent experiences with the accounts already written it seemed a number of issues could be identified as common to all of us.I felt that I wanted to be looked after in the practice area but instead I was unsupported. At the same time I was caught in the middle - between the women and the hospital since I was neither a member of staff or a client. My needs as a student - to complete a certain number of procedures (for

APRIL 1992 - **Managing the sessions**

Nine group members attended this workshop,one had left the course. The session went well. Starting with an up date on what had been happening enabled the group to vent their thoughts. The difficulties of trying to implement theory and ideals, in practice came across and although disappointed and frustrated the group generally seemed to be enjoying the course and particularly enjoyed talking about it. There always was plenty to discuss but the sessions did need to be "managed" - otherwise they talked across each other.

I enjoyed being with them and felt excited by what they were saying. They had an analysis of what was happening to them and suggestions about how things could be different but also expressed feelings of powerlessness. They seemed to enjoy the opportunity to reflect on what was happening and appeared open in discussing the issues and difficulties identified. We discussed what they should do and whether they might talk to the Director of Midwifery Services. They also asked me about the other group inquiry - were things better there? I was frank about my own views of the issues raised and asked questions about whether for example the possible conflict between their needs as students and the demands of service could be explained by a tension between education and service? They thought it could. In response to questions about the other group I explained that I did not wish to be drawn into making comparisons between them,

assessment purposes) seemed at times to conflict with the needs of women. This indicated a tension between education and service. There were occasions when the theory and practice did not seem to match up and this too added to a sense of frustration and stress. Did hospitals exist for the staff rather than the women and are the needs of midwives and women in conflict? It could be that the hospital organisation and protocols dictated what midwives do and prevented them from acting as they would wish. I concluded that hospitals are not a good place for a woman to have her baby since I seldom saw a "normal delivery" and I wondered if over time I might begin to believe that an episiotomy is generally necessary.

If I could I would have made changes in the organisation and delivery of midwifery care which would promote a holistic approach to midwifery care and at the same time, improve the learning experience. I would have changed the booking system in the ante-natal clinic and have clinics outside hospitals or home visits. I would reorganise care to increase continuity and allocate students to work with women and follow them through their care. I thought students needed to be taught practical skills earlier in the course so that they could do some simple things when they arrived in the clinical areas (for example making a bed and taking a blood pressure).

I would also increase the numbers of staff and only nominatea few as link midwives for many of them are not suitable since they are inexperienced and under confident themselves. I would require qualified midwives to attend more frequent in-service training and improve communication between the school and the service. There are many obstacles to bringing about change and as students we had very little power. I needed the encouragement and support from the school but instead I felt abandoned. We thought about raising these concerns with the Director of Midwifery Services. Problems of money, power and low morale amongst staff are not easy to overcome but even in small ways through assertiveness training, education, information and joint training for students and qualified staff things could be improved.

suffice to say that some similar themes came up but other things were different.

In a discussion about the group inquiry process advantages and disadvantages of being in groups were identified. It could mean that individuals felt less isolated, supported and in a safe place where they could express opinions and feelings. It could also mean that individuals felt compromised for if a majority view dominated then it could become difficult to speak out. It was also recognised that groups could become 'one-track' and or dominated by one person. Being part of a student group was important to them and in some cases was helpful in enabling individual members to continue with the course. They said they needed guidance in deciding what to do in this inquiry. It was suggested that they write about a positive and a negative experience for next time which everyone agreed to do. My role in the group remained that of leader but there was a willingness to participate in the work and to be involved in making decisions about what to do.

Afterwards I spoke about the idea of looking in more detail at "normal midwifery" and suggested that they might begin to collect some material about this which we could look at in a later session. They were keen to do this.

WORKSHOP 4 ***"Philosophy of care - a midwifery model"***

I was feeling increasingly frustrated by the kind of care women receive and there were only limited opportunities to establish a good relationship with them. My account of positive and negative experiences illustrated this:

"GOOD AND BAD EXPERIENCE
My good and bad experience relate to each other and have been repeated several times.
POSITIVE EXPERIENCE
My positive experience is that of sharing in the birth and labour of baby and women. The emotions and bond that developed between myself and the women, and being part in experiencing the incredible miracle of new life.
NEGATIVE EXPERIENCE
My negative experience is going to see the mother and baby the next day, and realising I hardly know her, recognise her even her voice is unrecognisable. We are after all strangers (I feel it must feel like having a drunken one night stand) I feel this situation is not natural and emotionally causes conflict. Continuity of care would of course be the answer, and I worry that as a midwife it will take me many years before I will get to the community because it does not seem to happen in hospital."

I recognised that being a midwife is more than being a "best friend" but the emotional support seemed most often neglected by midwives I had met Is this because they become 'burnt out'? I wasn't sure but it did seem that the kind of care I wanted to give women was not available to them, especially within the hospital setting.

My philosophy of care was that midwifery should be about "putting women first". However others in my group felt this did not sufficiently take account of the importance of the midwives' knowledge and skills. As midwives we do need to be able to do certain things and have practical

JUNE 1992 - **A different agenda**

Eight of the group attended two others were absent. A tutor had telephoned me to confirm the arrangements and said that the group were pre-occupied with exams and would rather spend this afternoon revising. Indeed during the workshop the different priorities of the group were apparent. There were no comments on the feedback I had sent and I couldn't help wondering if they had even read them? I asked them what they hoped to get out of this session - they explained that they came simply because I asked them to. This was disappointing and highlighted questions about the relevance of the research for them. They told me they had plenty of opportunity to talk to each other and didn't need me as a facilitator for the group so I reiterated the aims of the inquiry and asked how we might share in agenda setting. They wanted to make public their views and to know what other groups' experiences were.

What followed was a rather loud and disorganised meeting. Their anger and frustration about the course spilled over into the inquiry and they were irritable, resentful and hostile. The meeting gave an additional focus for expressing this. I constantly kept trying to structure the discussion but some group members were very outspoken and hardly gave anyone else a chance. Few had prepared for the meeting as agreed or written their accounts. They were unable to identify what criteria defined an experience as good or bad. Instead they talked about "feeling good" or "feeling

abilities which a "best friend" might not have. Perhaps after all it was a question of emphasis - whether skill and knowledge is at the expense of putting women first or whether those skills can be used as a means of putting them first?

I have often referred to the idea of "normal midwifery" and one way it could be defined is - "what women want their midwife to do when there is no complication". Thinking about this I realised that it raises many more questions than it answers. Is normal midwifery the same as normal delivery or can a woman with an "abnormal" pregnancy receive normal midwifery care? As Downe (1991) says who decides what is normal - midwives or doctors and is defining the normal important or not? How many definitions of normal are there? Does normal describe the woman's physiological state or something that midwives do? Even within the midwives rules "normal" is not clearly defined but it is assumed that a consensus exists, that we all agree what counts as normal when clearly we don't. Nevertheless I did believe that the midwife should be able to make clinical judgements and have confidence in her own ability. It seemed that the use of technology undermines this judgement and encourages a situation, especially in the hospital where midwives constantly defer to doctors.

I initially identifed many skills that a midwife should learn but later realised some were not desirable. For example ultra sound scanning could be a skill midwives do not require since palpation should provide adequate information. Instead I would add teaching breast feeding, parenthood and pre-conceptual care to the skills of the midwife which I listed earlier and emphasise the need to learn self-reliance and the ability to work independently. But where do ideas about midwifery come from? I wasn't sure and I wondered whether I was selected to this course because I already had certain views of midwifery.

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negative" and the strong emotions involved in caring for women. I suggested that this related to some underlying philosphy of care which they called "putting women first". We then discussed the importance of childbirth as a normal event and what was normal midwifery?

This caused a lot of confusion and debate and led us to the next question- what did the group think midwives needed to learn? They had expectations of what the course would or should cover and I asked them to be explicit about what these expectations were.

It was difficult to sum up the session. Reporting it was difficult since there was little agreement in the group and they seemed unable to articulate clearly just what their views were. There was no agreement about what counted as "normal" midwifery or pregnancy even though they often drew upon the idea as a point of reference. They also did have a set of values and beliefs about what should happen in delivering midwifery care but these remained underexamined in the group. There was little enthusiasm for the next meeting in November.

WORKSHOP 5 ***The context of care***

I believed care should be women-centred but it seemed this was often not the case Instead care was organised in a way that more often attended to the needs of doctors and midwives. For example, care was routinised and standardised - hospital routines such as ward rounds cut across what may have been preferred by the woman. A woman may be active and mobile in early labour but expected to get back to bed to be examined by the doctor. Care was standardised to conform to hospital policies rather than individualised according to the needs of women. Even bringing women together in one place suited the interests of doctors not necessarily the pregnant and labouring woman.

Power relationships within midwifery and the hierarchical structure restricted midwives' practice and students even more so. The organisation of the hospital was a means of controlling women, students and midwives. Shift patterns of working were primarily concerned with meeting the demands for the management and control of midwives skills where concerns about staffing cover take precedence over continuity of care in the interests of women and their carers. As a result midwives did not move around the hospital but the women did and their care was fragmented. This meant that as a student I got little opportunity to follow a woman throughout her pregnancy, labour and postpartum period. Such a system keeps women and midwives apart and undervalues their commitment to each other. While this system centralises resources in the hospital community services are limited. Instead I thought that a named midwife for each woman and each midwife having a case load would improve both the standard of midwifery care and facilitate my learning as a student midwife.

A further feature of the context of care is the care environment which is sterile, lacks privacy, isolates women and detaches them from what is familiar and comfortable. It is this unfamiliarity with the hospital

NOVEMBER 1992 **- Feeling lost**

I felt challenged by the June meeting to re-examine aspects of group inquiry. The idea of sharing agenda setting presupposed that the participants in group inquiry were able and willing to share in that process. The demands of the course on the group (notably exams) and other personal circumstances meant that the inquiry was not a priority for them. It probably was also an indication of what they saw as my job. As was pointed out to me - they came to the sessions, because I asked them to take part. At one level this seemed a rather weak explanation. The other aspect of this was that taking part in research did use up resources - of time and effort. I was disappointed that the group seemed unable at this time to expend more of their energies into the group work. Perhaps it appeared to have very little relevance and therefore they were reluctant to spend much time on it. So how could it become more relevant? On the one hand I was faced with an impossible task. Unless the group accepted and shared responsibility for what happened in the inquiry how could I make it more relevant? For the very fact that I decided what may count as relevant would probably mean it wasn't! What a double bind! I had tried to explain this to them. It seemed that my position was a rather an uncomfortable one. There were also constraints upon me which I had only partially presented to the group. Following the meeting I discussed with MRA and my supervisors the idea of bringing the two student groups together and though it was agreed this would be a mistake I

environment which, as a new student on this course, I identified with strongly.

Recognising these constraints on practice it was apparent that questions may be raised about how far midwives are "autonomous practitioners". When I challenged what they did I met with hostility and anxiety as the midwife appeared more concerned about complying with hospital policy than her accountability to the woman. As a student I prioritised my responsibility to the woman and thought information should be made available in order for her to make informed choices for example about whether she wished to eat during labour. It seemed that the qualified midwives were beaten by the system, disempowered, and both unable and unwilling to rock the boat. I felt the only option was to find ways of subverting formal policies in order to give appropriate care. Evidently there were conflicting views of appropriate care but the flexibility to allow women choice in their care often seemed lacking.

The diagrammatic representation of the organisation of midwifery service illustrated the split between antenatal, intranatal and postnatal care (see appendix 17). While there is an overlap in so far as a few individuals have contact with the woman throughout care more often in the case of midwives different members of that group are involved in the care. The woman was at the centre of care in this diagram and a non-hierarchical structure is represented. In a sense this was more closely related to what in my view should have been the case rather than a representation of the management and hospital structure with which I was unfamiliar. The representation of the educational establishment again puts the woman and baby at the centre and distance between students and other groups indicates a decreasing influence on their learning. In view of the infrequent contact with the university lecturers they were seen as very distant.

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remained unclear as to why. So just what was the potential for change from group inquiry? How could the group communicate their concerns to others? Was the evaluation report and my thesis sufficient for them? They could write something else but I feared that would detract from the continuing analytical work of the inquiry and would become an end in itself. So here was I setting the agenda.....

It was striking how despondent members of the group were feeling in the last workshop They had moved from being a determined and outspoken bunch to being much less certain of things. Now there was talk about getting a qualification and leaving the system as fast as they could. They were disempowered and uncertain about how to tackle the widespread problems they had identified. There was also some evidence of a breakdown of consensus in the group. Initially they had spoken almost as one voice. Now there was dissension. Perhaps idealism had become tinged with realism/pragmatism or as seemed more likely in several cases, they were disillusioned. On the other hand it may be that those who deferred to what others said at the beginning were now finding their voice and were more ready to challenge others in the group? I had a sense in which where there was order now there was disorder and, as I remarked to some of the group, that was consistent with other experiences/accounts of education that I had come across. The question "what is normal midwifery?" seemed to emphasise some of the groups' confusion. After all they had been

While I aspired to "normal midwifery" I recognised that there other approaches and a medical model of midwifery predominated. Aspects of these which I had identified were numerous and by then a familiar part of my student experience: It seemed there was a conspiracy about withholding information from woman particularly about the place of birth and their right to be delivered at home if they wished. This was tied up with the view that women should deliver in hospital where resources were centralised and a steady supply of women created for doctor (and midwife) training. Intervention was expected and automated care replaced some traditional midwifery skills (e.g. foetal monitoring). These "toys for the boys" created a situation where the woman was seen merely as an extension of the machine and midwives were no longer required to stay with her. Instead the midwife role was redefined as a nurse role, increasingly powerless and subordinate to the doctor. In this model pregnancy was considered pathological and a women needed to prove her normality and her right to deliver normally. Such a rigid and inflexible approach to care presumed that scientific knowledge (Drs) is superior to nature and culturally specific (i.e. Western) values were taken for granted. I do not reject completely that at times there is a need for medical intervention and support; and for some of my group it was reassuring to have that support. However the dominance of this approach to midwifery had undermined the ideals and beliefs I valued at the beginning of the course. The conflict between those values and intentions and the practical demands of the course and the work I was doing had effectively worn me down and reduced my ability to question and challenge current practice.

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lamenting that they were unlikely to experience "normal midwifery" so perhaps it was hard not to lose sight of what it could mean.

I arrived at the department early only to find it empty! Evidently the education centre had moved and no-one had told me! Ten students were present at this workshop and one other had failed the first year exams so was retaking the year. Another had passed the resits. They all remarked how low and worn down they were feeling. They found it hard to define what might be seen as "the context of care" and only slowly did the discussion develop. Drawing a diagram of the maternity services and the educational establishment provoked a lot of discussion but the management structure was unknown and remote from them and they felt it had little impact on their daily lives. Describing a medical model of midwifery which the students had objected to and seen as distinct from their view of midwifery care was less clearly articulated in this session. In part because it had become so familiar to them they found it hard to distance themselves from it. They were labouring under the pressures of the course and had become less able to develop a critique of their experience as time had progressed. The daily struggle had worn them down and they appeared dissillusioned and disabled. The anger and energy had all but disappeared and although they were not happy about much of what went on they were more accepting of it.

WORKSHOP 6 ***Midwives are not nurses***

I agreed with Kargar 1990 that it is important to learn traditional midwifery skills but I seldom worked alongside a midwife with a more 'traditional approach' to care and it did seem that as Kargar says the many midwives are dependent on technology and high tech machines. I rarely used a Pinard stethoscope and I believed many of these skills are being lost, skills I hoped to learn and I felt frustrated that these opportunities were unavailable to me. Instead, in my second year, I was on placement in non-midwifery areas.

Just when I had learnt some midwifery skills during the first year I went to the non-midwifery areas where I felt de-skilled and like a fish out of water. I felt strongly that the time spent in non-midwifery areas should have been spent in midwifery settings learning and developing the midwifery skills which I saw as essential to becoming a competent and confident practitioner. Much of the time I was observing or participating in nursing care which seemed to have little relevance to my role as a midwife as illustrated by this account I wrote:.

"Experience on a paediatric ward
Student MW X was looking after a sick baby on a paediatric ward. The baby was being fed by nasogastric (NG) tube, but had pulled the tube out and it needed replacing. Student MW X was working with Student Nurse Y. Student Nurse Y said "would you like to put in the NG tube?" Student MW X said "No, I've over done it before, I'll watch you this time". Student Nurse Y said " you really should do it, I'll tell you everything as you go along". Student MW X said "OK i will, but don't go away?" Student MW X did the terrifying deed and when it was over student Nurse Y said "I'm glad you did it because I've only inserted 2 NG tubes before and both were on adults". Student MW X was a bit shocked. Later 6 medical students arrived to study the baby. During their examinations of the baby the NG began to come out. Student MW X said to a medical student,

MARCH 1993 - **An outsider, looking in**

The other aspect of my role in this group was to try to control the discussion. At times it seemed I was superfluous to it however there were group members who had been inconsiderate and did not always allow others to speak. At moments like this I intervened and tried to move the discussion on or give someone else a chance, though I felt out of control much of the time and something of an 'outsider'.

Deconstructing accounts

At the beginning working with this group was exciting because they were politicised and articulate. They had an account of what midwifery was about, and what their role would be in caring for women but asking them to examine this in more detail, to deconstruct it, had become difficult to do and they seemed resistant to doing this. In addition they were experiencing a contradiction between an account in which they saw themselves as powerful and able to change "the system" and the feelings of powerlessness with which they were now faced.

There was still a resistance and defiance towards "the system" and injustices they faced but a strategy for dealing with them seemed much less worked out. What a sad state of affairs. Or was this a positive outcome? Could this represent an increasing awareness of their own ideological position? If the group work could systematically analyse

"Perhaps you could take out that NG tube as it has come loose." The medical student did so and then said " I've never done that before did I do OK?" Student MW X said "Nor have I done it, I thought you'd know what you were doing, that's why I asked you to do it".
It was often unclear what I should be doing and there were few specific objectives for these placements "

I had been anxious about going on placement in the nursing areas though one other in the group had some experience of nursing I was worried about how I would cope with sick and very ill patients. In particular caring for babies and children who were ill and seeing them in pain and suffering was very difficult. The disabling effects of physical and mental impairment raised many moral issues about the quality of life for babies with impairments and the midwives' role in delivering them. I also considered the responsibilities of parents and professionals in cases of child abuse. For some of the group these experiences highlighted how others cope with sickness and death and I was able to learn about what happened to those babies traumatised at birth and about other needs women have as mothers. I also gained some insight into the work of other specialities but I still questioned the amount of time I needed to spend in nursing and how much overlap there is between nursing and midwifery skills.

In many respects nursing care was very different and nurses' orientation to their work contrasted with the midwives' role. Nurses and doctors seemed desensitised and hardened to suffering, unaware of non-medical needs of children, mothers and fathers. Nurses deferred to doctors constantly, were rule-following, obedient, conformist, unquestioning and task-oriented. While I recognised that many midwives I had met were similar and behaved as obstetric nurses this was not how I understood the midwife role. I do not believe it is necessary to train as a nurse in order to become a midwife and I believe that as a student midwife I can learn essential 'nursing skills' (e.g. aseptic technique) in a midwifery setting.

this rather than continue to see the meetings as just another opportunity to chat perhaps there was a possibility of promoting a coherent and very powerful critique of their circumstances.

I waited outside the classroom as one of the midwife teachers was talking to the group and the door was closed. Then three students came along and invited me in. The teacher, not noticing my arrival continued talking and though the students all saw I was there no-one asked her to go or drew her attention to me. All this contributed to a feeling of being an intruder and an outsider, I certainly didn't feel like a welcome visitor but all ten students remained there for this workshop.

I often felt quite uncomfortable now in this group and having received a letter from one of them saying they didn't feel able to express their opinions, I was anxious to ensure that in this session everyone had a chance to speak. I had therefore set it up to allow more individual comment. This in fact did work quite well but since the group was fairly large - it took longer for each area to be covered - just giving time for each person to have a turn talking about their nursing placement took half an hour. Mindful of the time and a need to discuss how to proceed with writing the report, the 'nurse'/non-nurse debate did not get explored as fully as it might have done. However this may in part have been because in the group's view that was no debate for as

Until this time I had not had contact with nurses and only in these placements had I met student nurses who seemed to run these areas. I saw midwives and nurses as distinct but it seemed that of itself pre-registration midwifery education could not ensure that midwifery is seen as a separate profession. With such a large amount of nursing input to the course and within a context of care which limits midwifery practice other changes need to take place. In order to work with women as midwives, we first need to empower ourselves since only then might we empower women to choose the kind of midwifery care that they would wish for themselves.

Looking back over the first eighteen months on this course I have struggled to maintain the enthusiasm and commitment to working with women which I began with. My ideals have been challenged and undermined and increasingly I have felt frustration, anger and disappointment about midwifery care. There have been times of great stress (especially at the end of the first year exams) and despondency and I have become progressively demotivated but I keep going. I still want to become a midwife and I want pre-registration midwifery education to succeed but more than anything I want to see improvements in midwifery care.

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far as they were concerned there was no need to train as nurses first and they did not need nursing experience to become midwives (although it may have some value). Talking to them then it seemed almost as though they had become new students again - thrown into unfamiliar situations in the nursing areas which some of them were uncertain they had the personal resources to deal with.

Overall the session was much more 'restrained' in so far as discussion didn't get out of control with everyone talking at once. However the pace was so much slower that we covered fewer topics and though a range of diverse experiences were highlighted we didn't have the opportunity to analyse their accounts for differences/similarities or identify key issues raised.

WORKSHOP 7:MAY 1993 - Writing a report on Group Inquiry 2

As in Group Inquiry 1 I asked the students to prepare for this final workshop with three aims in mind. To reflect on being a pre-registration midwifery student, to reflect on the group inquiry process and to assist in constructing a public account of group inquiry and our views of being a student on this course (see appendix 14). Copies of earlier feedback (see for example appendix 15) had been circulated to assist in a review of the material that had been generated over the past eighteen months. This workshop provided a chance to collectively decide what to include in a report on group inquiry 2.

Making sense of the past

Since it was a friday afternoon before a bank holiday weekend I decided to travel by car to the meeting. This gave me a different view of the location of the hospital as not merely on a dual carriageway but actually in a residential suburb.

Prior to the meeting I chatted to some of the group in the hospital canteen. They told me that during the morning they had been complaining to the course director about many aspects of the course and *expressing* their dissatisfaction.

Two of the group were absent. Of those present it was evident that they had not prepared for the session and they were feeling embarrassed about that. This immediately led into a discussion about how they felt *they they had* contributed very little to group inquiry. They expressed a view that group inquiry had involved more than they initially realised but because they had committed themselves to take part and knew it was also part of my PhD work they had kept coming, otherwise they might have missed some of the workshops. Some of the group then said they still did not fully understand what group inquiry was about so this session became very much about making sense of what we had done. I couldn't help feeling that part of the difficulty in understanding the inquiry was that they had not read what had been given to them in the way of feedback and even not having prepared for this sesssion was another missed opportunity for them to review the inquiry process and the many issues raised during it. However I did stress to them that their feelings were probably not simply attributable to individual difficulties but related more generally to problems with the method which I needed to discuss in writing it all up. For example the reasons why they had not read feedback had been related to the demands on their time and perhaps the low priority they gave the inquiry.

We discussed writing up and co-authorship of a paper and they were uncertain about how much involvement they wanted. There were also mixed views about being identified but they did seem to welcome the chance to see and comment on what was written before it was published. It was agreed that I would post the draft to each person and they would then comment and indicate whether they wished to be identified.

Overall the meeting did provide a more relaxed (ie less structured) opportunity to review the work we had done although there were points in the discussion when it seemed there was a danger of rambling over and reworking issues that had been discussed already, rather than agree what

needed to be included in the report. It didn't seem that the group felt it had been a waste of time instead they were saying that they would have liked more time to spend on it to do it justice and not having that time meant they had been rather "half-hearted" about participating.

I thanked them for what they had done and tried to emphasise the value and importance of reporting on the inquiry now, since what had been achieved could usefully contribute to the evaluation and promote a better understanding of what it was like being a student on this pre-registration course.

AUGUST 1993 - **Postscript**

As with Group Inquiry 1, all members of this group were sent a draft copy of the report and invited to comment. Four replied by letter saying that they were pleased with, and had enjoyed, reading it. It was described as "accurate" and representative of the group and individual's views except in one case. This student said that "it may represent the feelings of the group but I hardly identify with it". It was noted how the group's views and agenda had changed over the two years and in particular how "ideals" had become "modified" and "enthusiasm diluted". One of them found reading about their earlier views made her feel "uncomfortable". All agreed to be identified as co-authors of the report.

CONCLUSIONS

This final section, as in the previous chapter, underlines the central issues and questions raised by the inquiry. I shall focus first on the CONTENT and aspects of the students' experiences and views of the diploma programme before going on to highlight aspects of the inquiry PROCESS.

CONTENT

From the beginning students in Group inquiry 2 had an explicit political agenda. By becoming midwives they hoped to improve childbirth for women, promote change in health services for women and through, 'working with women' empower themselves and 'others'. Recognising the development of pre-registration midwifery education as historically significant and founded on certain ideological principles, these students saw themselves as participants in a political programme to advance the interests of both midwives and the women they worked with. They were self conscious about the advantages of joining with others to achieve this and valued being members of a student group. This in turn was regarded as a means of accessing the benefits of belonging to a professional group - midwives, who were initially seen as enjoying high status and regard in society.

Early in the course a gap between their aspirations and ideals and the 'reality' of midwifery practice opened up. While already having strong views about the kind of midwifery care women should receive, the group became increasingly angry and frustrated by their experience of working with other midwives. They placed themselves **between** women and the professional midwives and identified ways in which they preferred not to be seen as midwives. They were very critical of the care women received, especially in the hospital where they spent most of their time. In particular what they saw as a lack of respect for labouring women and inadequate emotional support was highlighted. Increasingly the students became disillusioned and disaffected as they struggled to reconcile the dissonance between what they believed should be happening, that is what in their view was good and appropriate midwifery care, and what they witnessed in the clinical setting. Moreover the apparent collusion of midwives in a system of care that appeared not to meet the needs of women caused the students considerable conflict and led to an ambivalence about the merits of training as a midwife.

Attempts to explain this state of affairs focused on power relations, the organisation of care, and their philosophy of midwifery. The group were acutely aware of the powerlessness of women in childbirth and the effects of a hospital system staffed by two key professional groups. Relations between doctors and midwives were of concern to them since, in their view, midwives were too often unable to take decisions without reference to medical personnel or formal hospital policies. Individual midwives were thought to have been disempowered by a hospital organisation that routinised care. The delivery of midwifery services was considered the product of policies that centralised resources, promoted a task-based approach to care, fragmented care and reduced flexibility. Poor staffing levels, shift work and low morale amongst midwives contributed to a hospital environment that was neither good for women nor did it provide a suitable learning environment for the students. In effect this created a situation where midwives and women were both divided and controlled, where the midwife's accountability to the hospital hierarchy took priority over her responsibility to the women. In this context the very idea that midwives were, or could be 'autonomous practitioners' was called into question. In addition, according to the students, they appeared to collude with a conspiracy to withhold information from women and actively isolate and weaken them. The lack of attention by midwives (and doctors) to the emotional needs of women was indicative of the neglect and poor care that the students observed.

The students were able to propose alternatives - an approach to care that would be enabling for women in childbirth and which would also provide them with a better learning environment. For them, major changes in the provisions of midwifery services would lead to a better education. If improvements could be introduced which gave women greater continuity of care by enabling her to get to know her midwife better and so establish better quality relations with midwives, students too would benefit. In their view being able to participate in "a holistic approach to care" would facilitate learning and enhance the support they too received from qualified staff. While in the current climate they felt abandoned, unsupported and without clear objectives, such changes could be expected to substantially improve the situation. They also lamented the lack of support from the college remarking on the distance between them and the midwife teachers and other teaching staff at the polytechnic/university.

Importantly the students explored their own philosophy of care and attempted to examine in more detail what 'normal midwifery' could mean. This led to more questions than were answered, while they recognised that midwives were chiefly responsible for caring for 'normal pregnancy' they were uncertain about what counted as 'normal' or how it could be defined. On the one hand it could be seen as what midwives did, but contradictory evidence, based on their experiences of midwifery practice in the hospital, had emphasised interventionist and technologically controlled childbirth. Midwives participated in this too which meant they found it difficult to identify what knowledge and skills were appropriate for midwives or what they felt important to learn. For, while wanting to argue that midwives had distinctive knowledge and skills, they were unclear what these were. They did however strongly assert that the emotional work or supporting women in childbirth was important though again, contradictory evidence suggested that in practice midwives seldom seemed to do this. This conflict exacerbated their own feelings of frustration and disappointment to such an extent that early aspirations to resist the pressures of "the system", to conform or become too much like the midwives they knew, became progressively weakened. Their strongly held beliefs and values about what midwifery should be like were undermined and increasingly they appeared tired and worn down, like the midwives they described.

Due to the timing of the inquiry and the diploma programme it was not possible to explore, in depth the group's views of nursing. However, the short time they had been on placement in nursing areas was sufficient to draw attention to the ways in which they saw midwifery as distinctive. Indeed the time spent in nursing areas was considered by many of them to be irrelevant and inappropriate. They argued that midwifery knowledge and skills could all be learnt by working alongside midwives and they questioned the extent to which nursing and midwifery overlapped at all. In highlighting differences they saw nurses as more deferential towards doctors and conformist with respect to hospital routines. They were also critical of nurses' lack of awareness of non-medical aspects of care - psychological and emotional needs. These criticisms paralleled what they had said of many midwives and one explanation for this was that the majority of those midwives were previously nurses. Curiously then, the group actually aligned nursing and midwifery practices while advocating a model of midwifery that would emphasise differences. In so doing

arguments for the pre-registration approach to midwifery education, as a route to midwifery without previous nurse training, were mobilised. An approach which they believed could empower midwives and in so doing empower women in childbirth. Despite the disappointments they remained committed to becoming a midwife and hopeful that in time, things would improve. Meanwhile here was a group in transition - in both a clinical and educational setting marked by upheaval and transformation, the future was, as yet unclear.

PROCESS

Initially this group had presented a united front, appearing cohesive and speaking confidently with one voice. I felt at ease with them as they shared a language I understood, about working for women, bringing about change and empowerment. The 'we' of the early sessions seemed unproblematic for it suggested that views were generally similar and any one could speak for the others. The group usually had a lot to say and getting a discussion going was always easy. However, over time what at first appeared as advantages for inquiring together, led to certain tensions and caused me concern. In particular while there was usually a lively discussion it was not always conducted in a way that every student could take a turn in talking. In my view, there was a surprising lack of consideration for others and at times, it appeared that some voices were silenced. This was confirmed by a letter to me, from one student who felt unable to express her opinion in the group. My concern then was to encourage everyone to talk and to structure the workshops in order that this was possible. In striving to reach some kind of agreement about what is was like on this diploma programme it was important that we adopted a procedure where diverse views could be expressed. If not, it could hardly be seen as 'democratic'.

In an effort to ensure that a democratic procedure was adopted I sought to control the discussions in two ways. First to enable each student to participate fully and secondly to develop an analysis of what was discussed. The lively discussion and debate was not always productive in so far as it enabled us to work towards a critical analysis of what was discussed. More often the workshops were seen as providing an opportunity to chat about what had happened, to exchange views and opinions on a particular issue but not as part of any effort to produce a coherent analysis. For this reason it seemed that while the group were happy to produce data, they appeared

less willing to analyse it and this was evident from the view that it was rather tedious and boring looking back over past workshop notes. In practice they seldom did, which added to the difficulty of analysis. Though they would agree to read the notes or write accounts, often this was not done. On reflection, in the final workshop, the students admitted that they had been "half-hearted" about their participation in the inquiry and had not invested the time or effort that it had deserved. So why was this?

There were at least three indications of what the reasons for this might be. First the group persisted in seeing the workshops as a chance for a chat, rather than a systematic inquiry process. As a result they began to feel that my presence there was unnecessary and pointed out that they did not need me to facilitate this kind of discussion. In any case, they felt that our workshops repeated discussions they had elsewhere. Secondly the inquiry appeared to have little relevance to them and they were sceptical about the possibility of it contributing to change. They were disappointed that I would not put them in touch with the other student group and critical of this (even though I offered them a list of pre-registration midwifery programmes). Thirdly, they were already faced with the demands of the course and working in the practice areas so taking part in this inquiry was an additional burden for which they may well not have had the time. In a sense each of these three explanations could in turn be related to issues of ownership and control which I refer to in the research diary and will return to in chapter six. But an outline of the issues is useful here.

At the first workshop this group showed, by their questions, a concern about the ownership and control over the research. Sponsorship by the Department of Health could be regarded as a constraint on what was to be achieved and their concern to question whether I, as a member of the MRA research team, had a fixed agenda, also drew attention to ways in which I might be constrained. Indeed their questions pointed to the limitations on their own participation in the inquiry, which was in turn negotiated via the midwifery department. The extent then to which they could 'own' or 'control' the inquiry was in certain respects strictly limited and this they were conscious of from an early stage. Indeed since I stressed that the workshops needed to be seen as fulfilling the principal aims of the research the students' contribution was circumscribed from the beginning. What followed was the development of a view that this inquiry was for me, that it could serve no useful purpose for them. Contained within this, was a

paradox that remained unresolved. For within these constraints, the potential for the students to set the agenda and ensure that the inquiry had more relevance for them was in many ways not realised. Rather they seemed to relinquish attempts to direct or control the inquiry in a direction they would find useful and instead left the work of analysis and structuring the discussion to me.

As a consequence, I felt set apart from them, an outsider looking in, unable to share the work of analysis or the responsibility for what took part in the workshops. My position became more uncomfortable as the inquiry progressed and when their anger with midwifery seemed to spill over into the inquiry, the workshops became more difficult to make sense of, or control. As the inquiry progressed increased confusion, dissent and feelings of despondency permeated the discussion. While their individual experiences resulted in disappointment and disaffection, the ability to produce agreement in the group was affected. Though beginning with a sense of unity and coherence the group, through both the educational process and the inquiry process seemed to become more incoherent and disordered. While they clung to their early commitment to midwifery, they had no such strength of feeling toward the inquiry and so their efforts were dissipated and any sense of direction seemed harder to find. Nevertheless they had continued to attend the workshops through a sense of obligation and loyalty to me for which I was grateful. The final workshop did however seem something of a relief for us all and provided a final chance to consider what it had all been for and whether it had been worthwhile. Perhaps surprisingly they felt it hadn't been a waste of time but that under different circumstances it could have been much more.

PART THREE -
REACHING AGREEMENT

CHAPTER 5

Ideological Dilemmas - Discursive Formations

Introduction

In one sense the work of analysing the workshops was carried out by each of the groups in the preceding two chapters. However while the accounts produced were a product of the dialogue within each group and may be seen as a representation of the discussion that took place, for the purposes of this thesis it is not sufficient. To satisfy my objectives I need to go beyond these group inquiry reports and the summaries at the end of each chapter, to produce another layer of interpretation, a *sociological* account. This chapter therefore integrates the material already presented by using the themes identified in chapter two as a framework for understanding the voices of midwives expressed in the other three chapters. In effect, here I allow the voice of the sociologist to speak again and to re-interpret what has already been written (-an ideological dilemma of one account dominating over any other). In the last analysis I must 'own' what has gone before and recognise that, in reflexively constructing my self as author of this thesis I have necessarily (re)-constructed the accounts of becoming a midwife and the voices of the midwives represented above.

This chapter is in three sections. A discussion of the CONTENT of group inquiry will revisit three central themes introduced in chapter two - participation, ways of knowing and emancipation. In order to discuss and analyse the contradictions, conflicts and debates underpinning the students accounts of becoming a midwife I shall refer back to chapter one which provides a discursive context for the group inquiry. This discussion will be organised under three headings. In brief, in the first section I will explore how the midwives aspirations to become 'autonomous practitioners' rests on understandings of what ***autonomy*** might mean and its importance for participation in midwifery practice and education. Secondly, the place of scientific knowledge in midwifery and the alternative claims that midwives make to ***care*** for women will also be examined. Thirdly, this will lead to an understanding of the claims to ***solidarity*** midwives often make - solidarity with women who seek their services, and as a group opposed to the oppression of women in childbirth. In this way I will demonstrate how the conditions for participation in midwifery, that is for becoming a midwife, are inextricably linked to a critique of scientific knowledge as a way of

knowing, and strengthened by an emancipatory interest through alliances with women.

1.0 'Autonomous practitioners' - Autonomy as a condition of participation in midwifery practice and education.

The idea of the midwife as autonomous practitioner is underpinned by a sense of separateness, distinctiveness and independence - a sense of ***identity*** . It also embodies a claim to self-government and self regulation. We saw in chapter one how the legal framework within which the midwife works was used as a justificatory strategy to assert her autonomous status, define her role and demarcate her sphere of ***responsibility***. But this legislation, introduced with the first midwives act in 1902, was seen as both constraining and enabling the midwife, for as Witz argued, it meant that the midwife

"was to enjoy discretion at the level of execution in her daily practice as an independent practitioner with her own clients, but within a sphere of competence prescribed by the medical profession and restricted to attendance on normal labour" (Witz, 1992:116 ibid).

Under the provisions of the later 1979 Act and within the current Midwives Rules (UKCC, 1991) the midwife's statutory responsibilities are affirmed. More recently the House of Commons Health Committee report and subsequently *Changing Childbirth* (DoH, 1993 - see appendix 1) restated the role of the midwife in caring for women during childbirth[1].

The effect of this legislative framework for midwifery practice and education is to set limits on those who ***participate*** and to formally codify the relationship between those categorised as 'midwife' from those who are not. This codification, as a form of licensing is a recognised aspect of "occupational closure" (Parkin in Hugman, 1991) and the professionalisation of occupational groups. According to Oakley & Houd, in the case of midwives, it was a response to *"the emergence of professionalised medicine"* (Oakley & Houd, 1990:24). Paradoxically the professional identity of the midwife was contingent on that of the medical practitioner for she became defined as that which he was not, as ***'other'***,

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1 For simplicity I use the term childbirth to refer to the care of the woman throughout pregnancy, childbirth and the puerperium but do not intend to define the midwife's role more narrowly in so doing.

as *'different'*. Furthermore the introduction of formal training requirements from 1902 marked a move towards *credentialism,* another strategy for professionalising groups (Hugman, 1991; Witz, 1992). A programme of education for the midwife was expected both to raise standards of midwifery practice and legitimate the knowledge and skills of the previously unqualified practitioners. Ambitions that the midwifery professions would become self-governing and regulating were however, at least in the eyes of some critics, impeded as the statutory bodies set up were first controlled by doctors, and later by nurses (Donnison, 1977; Abbott & Wallace, 1990; Witz, 1992). In chapter one I discussed how the establishment of the UKCC and National Boards, with midwifery committees (DoH, 1979), was regarded both as providing a framework within which the midwife could work independently, and as undermining the autonomy of the midwifery profession (Cardale, 1990; Cronk, 1990; Frame & North, 1990; Walker 1991; Royal College of Midwives, 1991). Frustration with a lack of midwifery power in the statutory bodies was expressed, particularly by the Association of Radical Midwives (ARM) and Midwives Legislation Group, through moves to draw up a new Midwives Act. The stated aims of this movement are to strengthen midwifery control over professional practice and education by emphasising the ways in which midwives are different from nurses. Proponents argue therefore that separate legal and administrative structures should be put in place for midwives and a separate education programme for *"if we lose control of our education, we lose control of our profession"* (Midwives Legislation Group 1990, ibid).

1.1 Emphasising differences

At the centre then of the development of a professional identity for midwives was an emphasis on professional differences between midwives and doctors. Moreover these differences were gendered, for midwives have always more usually been women, and histories of midwifery consistently draw attention to the ways in which patriarchy shaped the drawing of professional boundaries and the regulation of social practices (Donnison, 1977; Abbott & Wallace, 1990; Witz, 1992; see also Garmarnikow, 1978; Hearn, 1982; Oakley, 1980; 1986; Hugman, 1991 for discussions of patriarchy and professions). Struggles for autonomy by midwives have been marked by a continuing inter-dependence on the medical profession exemplified by the midwives own code of practice which stated, as we have already seen, *"the responsibilities of the midwife and the doctor are inter-*

related and complementary" requiring co-operation and mutual recognition (UKCC, 1991 ibid). However the government's support for 'shared care' was also seen, by midwives, as undermining and underusing the skills of the midwife (Robinson, 1990) . Furthermore, in 'abnormal' cases where the midwife is required to defer to the medical practitioner this serves to weaken her claim to independence and autonomy. While the midwife has responsibilities to care for parturient women, she has no rights in this respect, as some midwives have claimed (Downe, 1987; Walker, 1991; House of Commons, 1992) rather, the rights of women take precedence in recent midwifery policy, but more of that later. In relation to nurses, midwives have sought to emphasis other differences (Ball, 1982; Flint, 1986; ARM, 1981; Downe, 1990). First, that midwives have statutory responsibilities for parturient women and are required under the law to act independently whereas the nurse may be seen as acting under the supervision of the doctor (though this is contentious). Secondly, the midwife is concerned with 'normality' and 'health' whereas nurses are seen as traditionally oriented towards 'abnormality' and 'illness'.

So with respect to both doctors and nurses, midwives have emphasised differences. Within the fast changing education arena we saw how proposals for reforms in nurse education (UKCC, 1986) that appeared to subsume midwifery as a branch of nursing in P2000, were strongly resisted,(not least by individual midwives at the Department of Health). Direct entry midwifery programmes and later pre-registration midwifery programmes were regarded by supporters as an important means of asserting the professional identity of the midwife. Although earlier direct entry programmes enjoyed limited support within the profession (ARM, 1981; Ball, 1982; ARM, 1986; Downe, 1986; Flint, 1986) by 1988 Radford & Thompson concluded *"it seems that the whole issue is linked to a bid to re-establish the midwife as a practitioner with a distinct professional identity"* (Radford & Thompson, 1988:104). Support for pre-registration midwifery education became widespread and the number of programmes implemented in England indicated that this support has grown steadily (Kent et al 1994). Though the reasons for this development are complex, the ideologies that underpin this support became the central focus for this thesis. It is in this context that the two group inquiry reports must be understood, a context where ***identity politics*** (see chapter two, section 3.2) and the policing of professional boundaries is a major concern to

many. Let us turn now to a discussion of group inquiry in order to examine how the students constructed their own identity as midwives.

1.2 Participation in higher education

From the beginning the student midwives in Group 1 were explicit about wanting to become *professionals*, making what they saw as a career move which, through their participation in the profession, would enhance their status, improve their life chances and give them a level of autonomy many had not previously enjoyed. Yet even at the first workshop (GI 1 w1) they saw themselves as different from nurses, and therefore questioned the relevance of what they experienced at the polytechnic (which later became the university), where they felt out of place and no sense of belonging. They were also acutely aware of their future legal responsibilities as qualified practitioners, and anxious about the prospect of shouldering those responsibilities. This group identified themselves more strongly as midwives when, increasingly they resented having to 'fit in' with nursing students at the polytechnic where they went for shared teaching and learning. Yet in asserting *"I am a midwifery student, not a nursing one"* they felt isolated and misunderstood. They wanted a more clearly separate education programme for midwives since, at this site the pre-registration midwifery course had been shaped by institutional arrangements for providing P2000 -the nursing course with far greater numbers of nursing students (GI 1 w3). As a consequence it seemed to the student midwives that, just when they had got used to being part of a midwifery college, it was dissolved. For them this meant that midwives had lost control of their education and the dissolution of the midwifery college symbolised this loss. The sense of being *displaced* was evident in their story of the changes. They had no place to go when they were at the polytechnic, by then a university. Accusations that they were being *"childish and unprofessional"* signalled a breakdown in communication and a separation even from what others regarded as professional values. Struggling for independence they became disenfranchised and disempowered, not even able to access the university representatives or activate *"formal procedures for consultation"* (GI 1 w5). They concluded that midwives could not be independent within higher education, that their autonomy was destroyed and consequently their professional identity was under threat. In their view, moves into higher education amounted to a de-skilling of a profession which is 'practice-based' and a dilution of the differences between midwives and nurses.

Individual students reminded others *"I am not a nurse, but a midwife"* and were accused of thinking themselves better than nurses, rather than *'just different"*. Midwives' participation in higher education was seen as severely limited as they were *"under-represented"* and *"not equal partners in decision-making"* (GI 1 w5).

1.3 Participation in midwifery practice

In the practice setting[2] the autonomy of midwives seemed less problematic for Group 1. They were anxious to 'fit in' to the hospital routine and learn *"the rules of the game"* so not to be *"conspicuous"* . The hospital rules and structure of social relationships were regarded as functional to the work of a midwife and rather than questioning these, their main concern was to become competent and adept at working within them. It was more a question of getting used to shift work and becoming familiar with the bureaucracy and hierarchy than challenging it. For here *"I felt I was learning the proper stuff now and focussed more on the practice issues than the difficulties being raised in relation to the College"* (GI 1 w3). There were difficulties in the practice setting but these were understood as learning the necessary skills, gaining confidence and learning to cope with the stress of the workplace. Stresses which were much greater in the hospital setting than in the community where the student had one- to-one support (GI 1 w3). Weakened links between service and education (Kent et al 1994) also created difficulties when students were not yet comfortable with being left to work independently and where lack of support from both midwife teachers and mentors was disabling. Yet while these were weak links in the autonomy of the aspiring professional, the division between midwives and nurses in the hospital was clearly supported by them, as was the view that midwives should have uniforms that are distinct from nurses (GI. 1 w5).

While there were similarities between the two groups, by contrast, the other student group (Group 2) were consistently critical of the ways in which the hospital undermined the abilities of the midwife and prevented her working

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2 As can be seen from the overview of each diploma programme in chapters three and four, midwifery students gain practical experience in clinical/practice settings in hospital and in community services. Placement patterns do vary between courses and sometimes between students on the same course, where rotation into placements is related to the availability of local services (Kent et al 1994). There are minimum requirements laid down by the EEC Midwives Directives and guidelines set out by the ENB (1990,1993b)

as an independent practitioner. While both groups welcomed the opportunity to join a profession and expected that they would enjoy personal growth and increasing confidence and assertiveness, with a higher status and more highly valued place in society (GI2 w1, GI1 w1), for this group the hospital system proved to be an obstacle to overcome. *"The ability of the midwife to deliver the kind of care women might want"* (GI2 w2) was, in their view, threatened by the dominance of the medical profession in the hospital. Hospitals were seen to exist for staff and yet "*the hospital organisation and protocols dictated what midwives do and prevented them from acting as they would wish"* (GI2 w3). This led to frustration and stress amongst the student group who felt increasingly let down as a gap between education and service, theory and practice opened up. They felt "*abandoned"* and *"unsupported"*. Believing that *"the midwife should be able to make clinical judgements and have confidence in her own ability. It seemed that the use of technology undermines this judgement and encourages a situation, especially in the hospital where midwives constantly defer to doctors"* (GI2 w4). Care was standardised and routinised in hospital so that midwife practitioners were unable to work independently or autonomously, unable to exercise their own judgement or provide the kind of care that the students thought they would want to deliver, given the chance (GI, 2 w5). Here *"the organisation of the hospital was a means of controlling women, students and midwives"* autonomy and participation in care were ideals that these students felt could not be realised in this setting and the group concluded that *'the qualified midwives were beaten by the system, disempowered, and both unable and unwilling to rock the boat"* (GI2 w5).

With respect to nurses, Group 2 had little thought of them until they went on placement in nursing areas and unfortunately for this research, this did not happen until workshop six. Then it seemed to them that there was a disproportionate amount of 'nursing' in the course. They were quite clear that midwives were distinct from nurses and were both puzzled and frustrated that they had to spend so much time in these areas. It seemed that while pre-registration midwifery courses had been hailed as promoting a separate identity for midwives and enhancing their status as practitioners in their own right, much more was needed to achieve the level of autonomy that they felt was appropriate (GI 2 w6).

2.0 Science and Caring - knowledge and skills in midwifery

In a public lecture Ann Oakley explored how *"midwives care for women and obstetricians control and master childbirth"*. She argued that *"science, or reason"* supported the approach of the obstetrician while *"love"* characterised the midwife's role, that this opposition between science and love is embedded in *"a very deep-seated cultural divide"* , a dualistic world view, a world of "*opposites which sum up the terms of a continuing debate about the occupational identity and unique contribution of midwives to the care of childbearing women"* (Oakley, 1989:215). Here is how she described this world of opposites:

Midwifery and Obstetrics:conceptual domains (Oakley, 1989)

Midwives	Obstetricians	Emotion	Reason
Women	Men	Intuition	Intellect
Health	Disease	Nature	Culture
Normality	Abnormality	Feminine	Masculine
Art	Science	Community	Institution
Social	Medical	Family	Work
Subjective	Objective	Private	Public
Experience	Knowledge	Care	Control
Observation	Intervention	"Soft"	"Hard"
Practice	Theory		

In describing this *"language of opposition"* Oakley sheds light on the inter-professional rivalries between obstetricians and midwives. Her aim in this paper (as part of an ongoing research project), was then to suggest that love, or care, could be scientifically validated, that 'caring' or what she calls *social support*, can positively influence health during pregnancy. In her later book *Social Support and Motherhood* (Oakley, 1992) Oakley locates this debate between midwives and obstreticians, caring and control, as part of *"the status and gendering of knowledge in contemporary capitalist society"* (1992:viii). She questions the dichotomies that underpin current thinking about maternity services in this country and attempts to cut across these divides in a research project that, by design and content, tries to combine contrasting epistemological positions and methodological traditions and to promote a productive dialogue between them. She brings together the biological and the social, science and caring. As part of the project research midwives provided social support to a selected group of women and

collected research data in a randomized controlled trial. To a large extent this was seen as consistent with their professional training which*"emphasizes the role of the midwife as provider of client-sensitive care and as guardian of the concept of normal pregnancy. But it also embodies another somewhat different notion, that of the midwife as moral educator, leading childbearing women into medically acceptable ways of behaving"* (Oakley, 1992:132). The idea of a moral educator was not seen as appropriate for the study which defined social support as "*listening* "to women *"talking"* to them, *"giving information only when required"* and *"referrals"* to other agencies where appropriate (1992:132). Oakley differentiates between social support, clinical care and health education though as she acknowledges this went against the grain for the midwives who saw their role as providing care that included all three.

If we return then to the group inquiry reports, what did the students' mean by midwifery ***care*** and how did the concept of care mark out for them a role for midwives that is distinct from what obstetricians do? It is evident that ***care*** is an important concept in midwifery discourse and central to the continuing debate about the shape and form of maternity services. While Ann Oakley's work makes a strong case for the valuing of social support (as part of care) my interest here is how *'care'* is mobilised by midwives to legitimate a sphere of activity and a particular view of childbirth. We shall see that this does involve taking up a moral position[3] with respect to the women that midwives work with and the idea of midwives as "guardians of the normal" is a revealing one (see chapter one and section 2.3 below). While obstetrics rests on assumptions of a separate subject-object domain, and a prioritising of scientific knowledge, we can see how midwifery care emphasises a way of knowing and being in the world that highlights connections between midwives and women, and prioritises experience and practical knowledge. These contrasting approaches to childbirth are further legitimated by constructing a distinction between 'normal' and 'abnormal' pregnancies where the practical competencies and knowledge of the midwife are utilised in normal cases while the obstetricians' expertise is ascendant in abnormal cases. As Abbott & Wallace point out by studying the *"emergence of different discourses as they relate to the various caring professions and the way in which they were institutionalized through welfare bureaucracies"* (Abbott & Wallace, 1990:10), it is possible to see

3 For a fuller discussion of morality and an ethic of care see Tronto 1993.

their effects on professional practice. Ideologies of care are valued by midwives and were mobilised by the students in constructing their accounts of what it means to be a midwife.

2.1 Valuing experience and practical knowledge

Students in Group 1 were committed to *"encourage others to be strong in themselves, and.... make childbirth a fulfilling and happy experience"* (GI1w1) *"Caring for"* and *"communicating with"* others were seen as important in midwifery, as was *"promoting health"*. They focused on health and caring at the beginning of the course and said *"the whole aim of being a midwife is to produce a healthy mother and baby at the end"* (GI1w2). This group emphasised strongly the ***practical*** things they did, the practical skills they needed to learn and the importance of getting opportunities to practice -*"being able to do basic practical things like taking a blood pressure or listen to a foetal heart with a Pinard stethoscope was very important to me"* (GI1 w2). Confidence, self-esteem and being able to pass as a midwife were all contingent on developing these practical skills. ***Experience*** and learning by doing were considered of primary importance. Their frustrations with the course related to a lack of clear objectives for practice placements and not *"being in the right place at the right time"* in order to get practice in doing, for example, vaginal examinations (GI1 w4).

During the *"traumatic time"* of moving to the university, students in Group 1 invoked their practice based learning as central to their status as midwives and the guiding thread for their development,*"I didn't want to be part of the student union, I saw myself as a clinically based student midwife with theoretical input not as a university student with clinical input. I belonged to the RCM (Royal College of Midwives) and anyway students have no power. As midwives I thought we need to keep our identity as a practical profession and as professionals in our own right. I thought midwives are losing their skills and we need to fight to keep them rather than de-skill ourselves"* (GI1 w5). So midwives' power rested on the acquisition and maintenance of these practical skills while 'theoretical input' was regarded as quite separate and of secondary importance. This separation of theory and practice is often problematised by midwife (and nurse) educators and while some felt that the new pre-registration courses had potential in integrating theory and practice more successfully than traditional courses, others feared that increased distance between the practice or service setting

and the education institution led to a widening gap between theory and practice (Kent et al 1994). This group were grounded in the practice setting but did feel that there was a decline in opportunities to learn 'traditional midwifery skills' due to the increased use of technology in the hospital (Kargar 1990, GI1 w6). They valued these traditional skills and preferred working in the 'low-tech' environment of a midwifery-led unit and the community, except when tasks became repetitive or where care was fragmented, as in the antenatal clinic. 'Continuity of care' is a contemporary concern for midwives[4] and students in both groups were frustrated and disappointed at not being able to *"follow through"* a woman, or get to know her throughout her pregnancy, childbirth and the puperium. (GI w6) and this was strongly expressed by the account of the student who, after attending a delivery said, when visiting mother and baby the next day,*"we are after all strangers I feel it must be like having a one night stand"* (GI2 w4).

This emphasis on practical knowledge and skills while seen as a way of asserting a midwife identity at the same time may be understood as reinforcing the subordinate status of midwives in relation to doctors. As Hugman (1990) and others have pointed out, the work of *caring for* others is consistently regarded as low status and is commonly carried out by low status groups. He suggests that while all professions claim to *care about* the welfare of others, those occupational groups who both care about and care for others (through the carrying out of practical, day to day tasks), are generally thought to be less than 'fully professional'. Midwifery as a 'caring profession', alongside nurses, teachers and social workers is often considered in these terms. Moreover the gendering and feminising of these occupations as extensions of 'women's work' contributes to their subordinate status. What is invoked here is a hierarchy of knowledge and skills where precisely those valued highly by the student midwives are accorded less value that the scientific knowledge and technical skills of the obstetrician.

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4 Arguments for changes to maternity services and challenges to the current arrangements for 'shared care' often include a call for greater continuity of care. As I discussed above in chapter one, there is little agreement about what this means but it is often linked to the development of team midwifery. Team midwifery while taking many forms may be seen as part of a "professional project" to put midwives at the centre of care (Sandall 1992). The primary aim of increasing continuity of care is to enable the woman to get to know her midwife and reduce fragmentation of care (Flint et al 1989).

2.2 Emotional work

The importance of 'emotional support' was discussed at length in Group 2 where students often talked about the relationship between the midwife and mother. While they acknowledged and listed practical skills that the midwife did, they asserted that an emotional bond between a woman and the midwife was characteristic of a midwifery model of care. This bond was described as a form of friendship but was considered *"more than a best friend"* because the midwife had practical skills and knowledge which they could use in the woman's interest. Communication between a midwife and the woman were thought critical in ensuring that care was appropriate and that the *"emotional well-being"* of the woman was secured. As students they tried to talk to, and support women in this way (GI2 w2) but they became disappointed and disillusioned when the culture of the hospital militated against this kind of support and qualified midwives seemed no longer to 'care' (GI2 w2, w4). The organisation of care as *"routinised'"* and *"standardised"* practices further eroded the emotional and practical support offered to women, while midwives themselves were thought to become *"burnt out"* by the demands of an alienating and disempowering system (GI2 w5).

We see here how the valuing of emotional work by the students, while strongly believed by them, to enhance their role, in practice could undermine their claims to have knowledge and skills that are distinctive. The extent to which what they could do, as professional midwives, was qualitatively different from what a 'best friend' might do was unclear to some of them and in certain respects contentious, though in relation to what doctors did the difference seemed clear cut. This emphasis on emotional labour is gendered as Oakley (1992) argues (see also Graham, 1983) and draws attention to the importance the students attached to their connections with other women and the close personal relationships which they regarded as characteristic of midwifery practice (see below section 3.0). Attachment to others and the value placed on those attachments have been related to gendered identities (Gilligan, 1982; Ungerson, 1987) and in emphasising their connection to, and caring for, other women, the student midwives constructed a gendered, professional identity. While this caring relationship with women was mediated by other divisions of class, race, and education (Graham, 1991; 1993) as we shall see below they emphasised their position as women.

2.3 Midwives as "guardians of the normal"[5]

While students in Group 1 concentrated on developing skills and integrating into the practice setting the other students had a strong sense of how childbearing was pathologised and medicalised in the hospital where they worked. Like other 'radical' midwives (Downe, 1990; Flint, 1986, ARM 1981) they espoused an approach to midwifery that emphasised childbirth as a 'normal',and 'natural' process. They saw a role for midwives as *"guardians of the normal"* but were unable to find ways of achieving this as students, within the context of the hospital where they were based. While not rejecting entirely the use of technology in midwifery care and the need for medical intervention at times, they were very critical of hospital policies and midwife practices that supported intervention and control during childbearing. They recognised that doctors claimed to have superior knowledge and understood this to be part of the dominance of western scientific rationality. They saw women becoming extensions of machines that had become *"toys for the boys"* (GI2 w5) and were resistant to the idea of midwives becoming obstetric nurses. According to supporters of pre-registration midwifery education (and earlier direct entry courses) the midwife who is not trained first as a nurse, but enters midwifery via the pre-registration route is *"less inclined to look on childbirth as a pathological condition. They are orientated towards the normal..."* (ARM, 1981) and the role of the midwife as *"guardian of the normal"* , rather than as obstetric nurse, is expected to be strengthened by these entrants to the profession (see chapter one).

Following from this, students in both inquiry groups were critical of the lectures they shared with nurses and the practical placements in 'nursing areas'. They questioned the relevance of these, arguing that since they were not concerned with 'sickness' or 'illhealth' they had no need of 'nursing skills' or knowledge.[6] They emphasised health and wanting to work with healthy people and it was this that distinguished them from nurses:*"I thought there were differences between midwives and nurses, that*

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5 Guardian - attendant, carer, champion, conservator, curator, custodian, defender, depositary, depository, escort, fiduciary, guard, keeper, miner,preserver, protector, trustee, warden, warder. (Chambers thesaurus 1992).

[6]There were others involved in pre-registration midwifery education however who felt that nurses and midwives had much more in common and therefore that shared learning or a 'foundation year' was appropriate (Kent et al 1994); see also Kent (1995 in press) for a discussion of shared learning and nursing placements.

midwives are practitioners in their own right and they don't care for the sick but healthy women who are pregnant but do not have an illness" (GI1 w4). The 'health focus' of pre-registration midwifery courses around the country was often cited as attracting students who had no interest in nursing the sick (Kent et al 1994) even though as I indicated above, the proposals for P2000 sought to focus on health in nursing education (see chapter one).

What was particularly interesting was to see how the House of Commons Health Committee and this group of students expressed similar views, how midwifery discourse had become accepted within official discourse and how proposals for policy reform were being shaped by midwives. The recognition of *"divergent philosophies of the management of pregnancy and childbirth"* (HoC, 1992 para 175 ibid) and an acceptance by the committee that *"becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health"* (HoC, 1992 ibid) represented a significant shift in thinking about maternity services. We saw how the medical view of childbirth and the view that hospital is the best place to have a baby was challenged. A challenge that was acknowledged by the Royal College of Obstreticians and Gynaecologists who, while admitting that they had become *"slightly too mechanistic in our approach to obstetrics.....too much science, too little caring; too little compassion, too much intervention"*, were anxious that the committee's report might be interpreted as too *"negative in relation to the technical and scientific advances in obstetrics"* (RCOG 1992:2 ibid).

2.4 Defining the normal

While much of the focus of discussion has been on the division of labour between midwives and obstetricians definitions of 'normal' and 'abnormal' remain in tact and are seldom critically examined. The student midwives, while often invoking the idea of 'normal midwifery', were uncertain what it might mean and though writers such as Curtis and Downe consistently argue that *"the definition of normality is fundamental"* (Curtis, 1986) to midwifery and midwives are *"experts in the normal"*(Downe, 1987) quite what counts as 'normal' is unclear. Although the midwives rules state clearly that the midwives' responsibility is to recognise abnormality and monitor normal pregnancies it seems that *"deviation from the norm"* is

understood as relating to medically defined parameters or rather a medical assessment of risk[7].

So as Oakley pointed out we see a language of opposition between 'normal' and 'abnormal' underpinning the occupational identity of midwives and students on the pre-registration midwifery course attempting to manage competing ideologies of 'care'. On the one hand a midwifery model emphasises the emotional support and 'caring' role of the midwife in 'guarding' or watching over a normal, natural process while this is contrasted with a medical model where interventionist strategies, using high tech equipment, to control and monitor the woman, assess risk and check for abnormalities 'pathologising' pregnancy and childbirth and alienating midwife practitioners and women. For the student midwives becoming a midwife was about developing practical skills, providing women with friendship and emotional support, promoting health and a view of pregnancy as a natural and normal process, in short, to adopt an ethic of care that rests on a particular moral attitude towards others (Tronto, 1993; Mendus, 1993) and ways of knowing that are seen to oppose the scientific paradigm.

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7 There is an extensive literature on 'risk' that has relevance here but which I do not have space to discuss. See for example Beck, 1992; Giddens, 1991 and in relation to reproduction and prenatal screening and diagnosis there is also a burgeoning literature - for example, Green et al 1993; Abramsky & Chapple, 1994.

3.0 Emancipatory discourse - an agenda for change

The relationship between a midwife and a woman during childbirth was described as *"a very special one"* (GI1 w2) and very *"close"*. This 'special' relationship may be understood in terms of a care contract outlined above. It may also be understood as solidarity in the face of what was described as an oppressive and controlling hospital environment where the autonomy of midwives was threatened and that of women in childbirth. An emancipatory discourse therefore was at the heart of the students' agenda (especially Group 2) and runs through much midwifery discourse. Emancipation from the effects of maternity provision where the medical model of care predominates, where the bodies of women can be seen as controlled by medical men (Oakley, 1986) and where midwives' activities are limited by the power and authority of obstetricians. This emancipatory discourse has recently begun to shape maternity care policy - as the Health Committee argued *"the debate about the place of birth, and the trumph of the hospital-centred management, have led to the imposition of a whole philosophy of maternity care which has tended to regard all pregnancies as potential disasters, and to impose a medical model for their management....."* (HoC, 1992 para 32 ibid). Although the committee claimed that the use of alternative criteria to judge the outcome of maternity services would not necessarily favour a particular professional group, but should enhance the control of childbearing ***women***, in arguing for improved continuity of care (as a means of enhancing women's control) they accepted that the majority of women *"regard midwives as the group best placed and equipped"* to provide this. So midwives are seen here as the group who will return control to the woman[8]. Midwife Caroline Flint claimed that *"they (midwives) are with women as they go through a life-changing experience. They are partners and colleagues. They work as a team, but a team of equal decision makers* (Flint, 1986 ibid). As "guardians of the normal" and *"advocates of the pregnant and labouring woman"* (Downe, 1986b ibid)

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8 In her discussion of the research midwives participation in the Social Support and Pregnancy Outcomes study, Oakley says they "were concerned to protect intervention women form 'unnecessary' medical procedures and to help them obtain 'necessary' ones. By comparison with these two mechanisms of effect, the giving of practical help, such as baby clothes or advice about welfare benefits, was probably less important in itself than as a demonstration of the basic position the research midwives adopted: that of being 'with woman' in the original sense if the term 'midwife'. It was because of this fundamental alignment of standpoints - woman and midwife - and the consequent legitimation of the mothers' point of view, that women offered the support intercention were able to build up and draw on their own resources of initiative, control and support, and by maximizing these to achieve more fore themselves and their babies than could otherwise have been the case" (1992:328).

midwives see themselves as protecting the rights of women and *"returning them to the centre of their childbirth experience"* (Downe, 1987 ibid). They see themselves as equals with women who seek midwifery care. They claim solidarity ***with women.***

3.1 Solidarity with women

Students in both groups had expectations that, by starting a pre-registration midwifery course, over the three years they would experience change on a personal level as they acquired new skills, gained confidence and took on the professional identity of a midwife. In addition, as women, they expressed a personal interest in childbirth and felt that by training as a midwife they would be dealing with something they could relate to -*"being a woman"* (GI1 w1)[9]. For the students in Group 2 this commitment to *"work with women"* formed an explicit political agenda to *"make a difference to other people's lives and have some influence....to change the system"* (GI2 w1). By empowering themselves they hoped to empower others by *"getting very close to women and working for change with them"* (GI2 w1). Becoming a midwife, being 'with women' was understood in terms of a shared interest in making childbirth an *"enjoyable and happy experience"* (GI1 w1) and increasing women's power and control over their care. For the students this meant *"putting women first"* (GI2 w4) and their *"allegiance"* was to women rather than to a particular staff group (GI2 w2).

On occasion this allegiance to women conflicted with the students' assimilation into the midwifery profession. As students they placed themselves ***between*** the women and qualified midwives *"in the middle, between the women who (they) could relate to and the qualified midwives"* (GI1 w3), as *"neither a member of staff or a client"* (GI2 w3). They identified strongly with the women in what was initially an unfamiliar hospital environment and prioritised their responsibility to women, even if this meant challenging the behaviour of qualified staff , for example, over policy about whether a woman could eat during labour (GI2 w5). Group 2 in particular were very critical of what they saw as *"a conspiracy about withholding information from women"* and asserted that women should be

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9 The number of men in midwifery is very small (Lewis 1991) and the number entering via pre-registration programmes is approx 1% (Kent et al 1994). There were no men in either of the student groups.

at the centre of maternity services (GI2 w5). In their view, the hospital organisation and hierarchical structure functioned as a system which *"keeps women and midwives apart and undervalues their commitment to each other"*, by isolating women and fragmenting their care. Much of the time students aligned the interests of women and midwives, believing that what was beneficial for one group was also good for the other [10]. But when, at times, they felt midwives did not act in the womens' interests they sought to distance themselves from qualified staff, blaming the system for wearing staff down and burning them out.

3.2 Professionalism - a conflict of interests?

It seemed then that there was sometimes a conflict between 'professional interests' and the interests of women which can be explained with reference to the literature on the caring professions (Abbott & Wallace, 1990; Hugman, 1991). As a professional group, midwives themselves became agents of control, setting limits on what women could do and the kind of care they could expect and receive.[11] Furthermore, attempts by midwives to become a stronger profession may be seen as contradicting the claims to work 'with women'. In a recent conference paper the Royal College of Midwives professional officer, Rosemary Jenkins, questioned whether increased 'professionalism' was a desirable aim for midwives and suggested that there was a danger of becoming *"elitist"* and *"protectionist"* (Jenkins, 1993). She proposed that earlier apprenticeship models of education and more *"traditional"* forms of midwifery care were more suited to the needs and interests of women. In advocating a break with nineteenth

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10 In her discussion of the research midwives participation in the Social Support and Pregnancy Outcomes study, Oakley says they "were concerned to protect intervention women from 'unnecessary' medical procedures and to help them obtain 'necessary' ones. By comparision with these two mechanisms of effect, the giving of practical help, such as baby clothes or advice about welfare benefits, was probably less important in itself than as a demonstration of the basic position the research midwives adopted: that of being 'with woman' in the original sens of the term 'midwife'. It was becasue of this fundamental alignment of standpoints -the woman and midwife- and the consequent legitimation of the mothers' point of view, that women offered the support intervention were able to build up and draw on their own resources of initiative, control and support, and by maximising these to achieve more for themselves and their babies than could otherwise have been the case" (Oakley, 1992:329).

11 In a response to the report of the House of Commons Select Committee, Ruth Ashton, then general secretary of the RCM asks *Who can speak for women?* She argued that "midwives cannot be women's advocates because their professional status, their skills and knowledge, by definition, set them apart from women in general" (Ashton 1992). She says therefore that "our aim must be to move to a situation where women are not equal partners in their care, but the senior partners".

century concerns to become a profession and expressing caution about what she terms increased *"intellectualism"*, Jenkins outlined an *'intellectual apprenticeship model"* for midwifery education that would combine the benefits of practice based learning and an ability to theorise about practice. She and others at the conference (Maguill Cuerden et al, 1993) wanted to promote the development of lecturer practitioners to support students in the practice setting and reduce what they saw as a widening gap between midwifery education and practice.

This view, shared by other midwives, (Kent et al, 1994) indicated a concern that by strengthening links between midwifery and higher education there would be a dilution of practice skills and students qualifying via this route would be too 'theoretical' in their orientation to midwifery[12]. This in turn set the pre-registration midwifery student apart from qualified staff who had neither a diploma in higher education or a midwifery degree, and caused confusion about what students might be expected to know and do on placement in the practice areas (Kent et al, 1994).[13] As students, Group 2 felt set apart from the staff who often seemed ill-informed about their course, the objectives and the assessment procedures (GI2 w3). Students in Group 1 had a more varied range of experiences, because they worked across three sites, and while all were anxious to be accepted by the staff, in some cases it took longer for staff to get to know them or be supportive. In the beginning the students in both groups felt other midwives resented them *"and there was a generally negative attitude towards pre-registration midwifery students"* (GI1 w1). Since the majority of existing midwives are also qualified nurses, having trained via the post-registration route, this contributed to their uncertainty about what to expect from pre-registration midwifery students who had not already adopted professional values or worked within the health service. Sceptism about the pre-registration students' ability to care for women who were sick, given their lack of nursing experience, was also expressed by staff and contributed to

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12 This view may be supported by the work of Benoit in Canada who argued that univesity educated midwives were more closely supervised in practice because they had reduced practical experience (Benoit, 1989; 1991).

13 It also raised questions about the differences between pre-registration courses at diploma and degree level, Interestingly both student groups were on diploma courses and at one site a degree in midwifery was also running but this was of no concern to the students who had nothing to do with the students on the degree course even though it was based at the university. Degree students however gained practical experience in another health district.

criticisms of the pre-registration route (Kent et al 1994). This pointed to divisions within the midwifery profession, a less unified approach to midwifery care and weakened solidarity with women.

3.3 Midwives and nurses -working together for change

Given this uncertainty about the merits of the pre-registration route, I want to refer back to the division between midwives and nurses and suggest that alliances between them have been necessary and in some ways beneficial. Where midwives consistently emphasised differences between themselves and nurses the opportunities for collaboration in education were not always valued, though there were clearly mixed views on this (Kent et al 1994). In the context of the university, (Group 1), midwives and nurses were thrown together and the size of nursing programmes and numbers of nursing students were seen, by midwives, to be prioritised. Yet here and elsewhere (Kent et al 1994), joining with nurses was both practically and politically expedient for it gave midwives a presence in the university that they could not achieve on their own. In this, and at other pre-registration midwifery sites, negotiations and bargaining with the local university by a College of Nursing and Midwifery, jointly sought to represent the interests of nurses and midwives and the development of midwifery education ran in parallel to changes in nursing education. While midwives felt that their special interests were not always adequately taken account of at the organisational level, it could be argued that they would have been left behind altogether if they did not join forces with nurses. In the case of Group 1, students were quite clear that these joint arrangements did not benefit them as ***midwifery*** students, yet as ***students*** they recognised that they shared common concerns with nursing students who were also critical of the dissolution of the College of Midwifery and Nursing. They had even tried to attend a student meeting with the Royal College of Nursing.

So in the higher education setting solidarity between nurses and midwives, and emphasising similarities, could sometimes be a strategic advantage even though critics argued that midwives had lost control of their education and that their voice was not heard (Warwick, 1992; Ho, 1991,1992). [14] The extent to which they share knowledge and skills remains contentious as the

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14 For a fuller discussion of the institutional arrangements for providing pre-registration midwifery programmes see Kent et al 1994.

students in Group 2 indicated in their comments about the 'nursing placements'. Yet I want to suggest that there is a possibility of unity in diversity. While differences between midwives and nurses may continue to be important (and indeed differences between midwives), *"identities are not fixed essences, locked into eternal difference. They are fluid possibilities, the elements of which can be reassembled in new political and cultural conditions. Politics is not, therefore, a power struggle between natural subjects. It is a struggle for the very articulation of identity, in which the possibilities remain open for political values which can validate both diversity and solidarity"* (Weeks, 1994:12). Therefore, collaboration between midwives and nurses need not necessarily undermine the autonomy of either group. Shared values as health professionals and a joint commitment to an ethic of care could provide the basis of continued dialogue between them and others, a dialogue in which the voices of midwives can be heard. For as Tronto (1993:21) suggests, *" care is not only a moral concept but a political concept as well. Care helps us to rethink humans as interdependent beings"* and can help us to prescribe an ideal for a more democratic, pluralistic politics where relatively disenfranchised persons may speak. [15] The extent to which this research, by adopting such a democratic ideal, could enable the student midwives to speak will be discussed in the next chapter.

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15 According to Mendus (1993) there are however a number of problems with extending the concept of care into the political world. She argues that we should be cautious in employing an ethic of care to pursue feminist ends not least because there is a danger of reasserting the difference between men and women as a biological one. Moreover, according to her, caring for distant and unknown persons, that is those outside the private realm (family and friends), is problematic since it lacks a realistic view of the modern world. She does not reject an ethic of care, but wants to find a way of integrating it with an ethic of justice. Mendus places emphasis on the distinction between chosen and given aspects of moral life. She says that if we see care as obligation and responsibility - as given - in contrast to the voluntarism of justice orientations; we can reassert the importance of an ethic of care in moral and political life. This, according to her, does not mean emphasising differences (between women and men), but rather it does mean rejecting the liberal emphasis on agency and seeing the contexts which give rise to obligations as multiple and conflicting. In this way similarities between people come into view as all of us (not just women) have responsibilities and obligations towards others. See also discussion of Benhabib's view of a care ethic below in chapter six.

Conclusion

In this discussion of participation in midwifery education and practice, science and caring, and emancipation, I have sought to elaborate on, and gain a better understanding of the students' accounts of becoming midwives. I have shown how the demarcation and protection of professional boundaries have been important for constructing a midwife identity. This in turn may be seen as a form of identity politics where 'midwife' is often invoked as a fixed and unitary category - a person or subject, with statutory responsibilities, who acquires the necessary education and training to carry out specified work. A closer analysis of midwifery discourse, in both the students' own accounts and the midwifery literature, shows how midwives consistently seek to emphasise differences between themselves and doctors, and between midwives and nurses. In asserting their distinctiveness from doctors they were seen to value practical skills and emotional work. This *caring for* women in childbirth was what both sets them apart from doctors and places them in a subordinate role. For this ethic of care, in seeking to reject the scientific paradigm of medicine, confines midwives to a low-status position within a hierarchy of gendered relations. Interestingly though, the medical model of childbirth attributed to obstetricians, has been increasingly criticised and the alignment of midwives as the group best placed to return control over childbirth to women, was seen as potentially liberating for both women and midwives.

However, the mapping of professional interests onto those of women was percieved as problematic by the students' and other midwife commentators. This pointed to questions about the extent to which midwives could represent the interests of women. Similarly, in the context of links with higher education for the delivery of pre-registration midwifery programmes, questions were raised about how far nurses and midwives interests overlapped. While some argued that just and fair representation depended on membership of a particular group, others could see that nurses might be able to speak in the interests of midwives. The extent to which similarities or differences between occupational groups (and within each group) were emphasised resulted in alternative views of the pre-registration approach to midwifery. In so far as these changes can be seen to undermine the midwife's professional identity and her claim to distinctive knowledge, they represent a threat - the view of many students in Group 1. But, as an opportunity to assert a midwifery model of care, to bring about change in midwifery education and practice which values those aspects of what

midwives do which are 'different' from other occupational groups, then the pre-registration approach could be regarded as empowering. Often this was the view espoused by Group 2, but the absence of associated changes in the delivery of midwifery services in the hospital, and an apparent lack of support for them, resulted in an undermining of their ideals and a questioning of professional values. Perhaps after all very little had changed, though in the longer term, together with proposals outlined in *Changing Childbirth* (DoH, 1993), pre-registration midwifery education might be seen to significantly alter what it means to be a midwife, to be 'with women'.

The next and final chapter examines what it meant to be "with women" in this reflexive project. How, when inquiring together could similarities and differences within each inquiry group be articulated? While the connections between knowledge and power have been seen to be important for understanding the students' accounts of becoming a midwife, how did this shape the inquiry process itself? How might a commitment to an ethic of care enlarge the possibilities for democratic participation and dialogue in this research?

CHAPTER 6

Inquiring Together

Introduction

In this chapter I want to explore the issues raised by doing group inquiry and the accounts of that PROCESS produced in chapters three and four. I shall refer both to my 'research diary' as an account of the inquiry PROCESS and to the account which was jointly produced (by the students and me) as part of the group inquiry report (see appendices 9 and 16). These accounts were produced from workshop notes, tape recordings and fieldnotes. The students contributed to the accounts of the PROCESS by the notes they provided in the final workshop to write each of the group inquiry reports (see appendix 14). My intention here is to critically examine group inquiry method - the circumstances and context of the inquiry, as constructed in these accounts. I will point to a number of concerns already introduced in chapter two which will enable me to extend my discussion of 'the politics of truth'.

The 'problems' of representation were outlined in chapter two. I was faced with the implications of my own status as author of this thesis and the extent to which each group could be represented as a unified whole. When discussing the inquiry in what sense could 'we' represent the views of everyone who took part in each group? Indeed the consensual (and realist) accounts presented in chapters three and four do appear to gloss over differences but they are intended to signify an agreement that was reached by each group. Central questions then are how was this agreement reached? Under what conditions did this dialogue take place and is the agreement reached an acceptable one? By accounting for the PROCESS of inquiring together I have sought, reflexively, to attend to the ways in which the agreement was reached. I have also differentiated between myself and the 'others' in the group for I was different from them in certain respects. Although we were all part of the group, part of a 'whole', my account of the inquiry marks me out as different from them. (Similarly, if each group member had written an individual account it would have been 'different' and variability of accounts could be expected.) But by situating my self in the group, as a participant in this dialogue, I am able to explore the issues raised when inquiring together and to examine the theoretical, philosophical and practical problems that need to be overcome in order to reach an agreement

that is both acceptable and legitimate. For as White argues we need to distinguish *"compromises which are acceptable but illegitimate from ones which are acceptable and legitimate"*, to distinguish between what appears as a consensual account but is a function of power relations and one which can be justified on moral grounds (White 1988:76)[1]. So in this chapter I aim to examine how far the accounts of becoming a midwife constructed by each group may be considered lawful (valid) and whether power relations could be understood as distorting communication (dialogue)[2]. This discussion therefore focuses attention on the relationship between knowledge and power, democracy and truth, in the inquiry PROCESS.

The chapter is divided into three sections related to the three themes of *participation, ways of knowing* and *emancipation* which were identified above in chapters two. In chapter five these three themes provided a useful framework for analysing what it means to be a midwife - 'with women' - but they are also central to the group inquiry method. I see them as important for understanding what it meant for me to be with the women who took part in this research. So here I want to assess how far group inquiry, as a form of feminist participatory research, can be 'democratic'; what is the status of claims to knowledge that participants in group inquiry might make; and, finally, what emancipatory potential, if any, did group inquiry realise?

First, the ideas which underpin a participatory approach to research will be examined further by developing an understanding of participatory politics. This leads to a discussion of central concepts such as equality, control , justice and fairness. Exploration of these, points to the difficulties of a democratic model of research and evaluation, difficulties which I noted in group inquiry. This discussion is crucial for deciding whether principles of democratic participation were, or could be, upheld. For what needs to be established here is how far these difficulties were inherent in the group inquiry method and the extent to which they are contingent on the particular organisation of knowledge and research in our society.

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1 This distinction shows how agreement may be reached through illegitimate or unlawful means and still be accepted. Justification on moral grounds I take to refer to the moral grounds that are deemed acceptable to those on whom the agreement is binding - see my discussion of Benhabib below in section 1.3.

2 For a discussion of Habermas' idea of distorted communication see Thompson (1984 chapter 8).

In the second section I go on to discuss how a discourse theory of knowledge is needed to explicate the relationship between knowledge and power in the inquiry process. Through a detailed discussion of Seyla Benhabib's work (1992) I shall show how the criticisms of the Enlightenment model of epistemology may be sustained, but also how the project of modernity may continue. According to Benhabib that project, informed by a discourse ethics and universal principles of egalitarian reciprocity and moral respect, may be seen as contingent on a radically procedural model of rationality. She outlines an approach whereby there can be unity in diversity, where through dialogue, agreement may be reached which does not elide differences between participants or render them invisible, but rather allows each of us to speak as *embodied selves*.[3] I argue that her approach is useful for understanding the difficulties in group inquiry. In particular the importance I attached to making myself *accountable* to the students in each group is seen as consistent with this discourse model of legitimacy. In distinguishing between a consensus and the attainment of agreement through rational dialogue, as Benhabib does, I support the view that a procedure, or method, for producing knowledge in this way is morally desirable. In order that the accounts of becoming a midwife which were produced during group inquiry, may be seen as both acceptable and legitimate, I shall examine whether group inquiry, as a method, was morally defensible.

In the final section, through a discussion of emancipation as a modernist project, I examine the claim that participatory researchers and feminists make to produce knowledge that is emancipatory. By returning to a discussion of feminist knowledge and a politics of difference, I discuss how far group inquiry produced knowledge that was with, and for, women.

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3 In her discussion of the tensions between a politics of ideas and a politics of presence Anne Phillips (1994) also examines how liberalism has been criticised for erasing diversity and difference. She argues that an emphasis on the politics of ideas, and the view that any one can represent the ideas or interests of another, does not address the problem of political exclusion. Instead she believes that it is a mistake "to treat ideas as totally separate from the people who carry them, or to worry exclusively about the people withouth giving thought to their policies and ideas" (Phillips, 1994:88). According to her what is needed are mechanisms that both take account of ideas and "that address the problems of group exclusion without fixing the boundaries or character of each group" (p89). While her arguments focus on the organisation of political life they also have relevance for an understanding of some of the tensions within group inquiry. In particular the extent to which I could represent the views of the students and how differences within each group could be articulated.

While I adopted an explicitly feminist agenda, and attempted to take the view of the students as "others", when constructing accounts of becoming a midwife, I recognised how relations of power and oppression shaped that process, and the content of those accounts. I sought to claim solidarity with the student groups in ways that were similar to the claims they made in expressing solidarity with women. Using Benhabib's work I show how ethics of both justice and rights, care and responsibility, can inform a feminist approach to participatory research. I conclude that, as Benhabib says, we do need to shift from a theory of consciousness that priorities experience to a theory of language that allows us to understand how it is discursively constructed (see also chapter two section 3.7). At the same time we need to bring into view some guidelines for arbitrating between competing accounts of 'reality'. This enables us to resist the nihilism of a relativist position, and to enter into a dialogue with others about the kind of life we would like and how it might be achieved. In the context of this inquiry this means seeing group inquiry as a way of opening up debates about the future of midwifery education, rather than closing off possibilities. The agreement reached amongst the student groups may then be seen as provisional but also as an important opportunity for them to tell their story of becoming midwives and for me to tell my own story of being with them.

1.0 "Situating the self"- participatory politics

As part of a democratic approach to evaluation the purpose of group inquiry was to explore the educational experiences of students on two diploma programmes, to give voice to the students' view of pre-registration midwifery education. This was expected to contribute to a public debate on current and future developments in midwifery education and, as part of the final evaluation report (Kent et al 1994), to assist in reaching some kind of agreement about the direction of those developments. Yet in the context of a government funded, national evaluation to what extent could group inquiry be democratic? For, as Seyla Benhabib says, *"the struggle over what gets included in the public agenda is itself a struggle for justice and freedom"* (1992:94). How could the students' voices be heard and how might they contribute to setting that agenda? On what basis could the negotiation and bargaining between participants in the inquiry take place? What constitutes a **moral conversation** if an agreement is to be a fair and just one?

1.1 Equality

When introducing group inquiry method in chapter two I highlighted the concept of ***participation*** and the active involvement of participants as co-researchers in the inquiry. Recognising that the intention was to encourage everyone to contribute to the different stages of the research, and seeking to promote what Heron termed *"authentic collaboration"* (see also Heron 1988:56), I was constantly questioning what the contributions of the different group members could be. From the accounts of the group inquiry process it seems that students were not clear what specific tasks there would be even though I consistently restated the broad aims of the inquiry (GI1 w1). They were unclear about what the inquiry was for and had not anticipated the time and effort that would be involved (GI2 w1, w6). I faced a dilemma from the beginning - if the groups were to participate in setting the agenda it seemed inappropriate for me to specify at the outset exactly what would be involved. For, as Reason says, participatory research may be seen as an *"emergent process"* (Reason 1988) and as a consequence the inquiry appeared to lack direction and structure. In many ways, therefore, it was not possible for me to specify a priori how it would unfold. Yet rather than this being seen as providing the students with an opportunity to determine for themselves what took place, they appeared at times puzzled by

my apparent unwillingness to tell them what to do when instead, I asked them to decide what should happen (GI2 w4). Why was this?[4]

The inquiry was located as part of a much larger project and access for it had been agreed with each of the two midwifery education institutions via the managers and teaching staff there. Through these gatekeepers I was introduced to the students. My situation was an ambiguous one in that while I expressed a wish to work with the group on equal terms, there were clearly inequalities structuring our relationship as 'co-researchers'. Inequalities that included my different status as a full-time researcher and PhD student, and differences between them in terms of age, educational background, class and ethnicity. Furthermore, my agenda was shaped by these differences in that I had a job to do and a thesis to write. One group even saw me as *"an official mouthpiece"* for their grievances and were uncertain what this could imply (GI2 w1). So while the students consented to take part on the terms that I initially set out, that is as 'co-researchers', there was only a very partial understanding about what, in practice, this might mean. While Reason alerts us to beware of differences in power or status that militate against the possibility of negotiating an open contract, in practice this makes little sense for such differences must always be expected. So if the idea of 'co-researchers' implies that these inequalities can be "bracketed off" or put aside (Heron 1988) this is problematic, for it suggests that we can become detached and disinterested participants[5]. It is also inconsistent with the view, expressed by Reason above (see chapter two, section 5.2), that group members may be expected to bring different skills, and knowledge to the inquiry. What seems to be embodied here is a liberal notion of participation and a principle of equality that requires

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4 Meg Miller (1992:52) discusses similar difficulties in her study of experiential learning groups and the role of facilitators in 'structuring' group discussion. She suggests that there was reluctance within the group to become autonomous learners but also that she may have lacked skills as a facilitator (p64). She also suggests that living with ambiguity and uncertainty is often difficult and therefore produces negative feelings. Miller uses Heron's model of facilitator style (1989) as a framework for understanding her role in the experiental learning group which comprised nineteen health care students studying for a BEd.

5 Heron (1988:59) suggests that the mental ability to "bracket off our the research ideas that pick our experience....and the tacit concepts involved in (my) everyday way of identifiying the content of the experiences" is a central skill, a phenomenonlogical discrimination that is crucial for a radical empiricism. While not suggesting that we "can eliminate explicit and tacit propositional constructs from the content of our experience" he does suggest that it is possible to suspend them and to allow the experiences -'phenomena' "to speak somewhat for themselves". This he says is at the heart of validity in co-operative inquiry if it is not to become a self-fulfilling and circular process.

researchers to adopt a kind of Rawlsian 'original position' in relation to the inquiry process - divesting ourselves of power, status and interests in order that we can position ourselves in a non-threatening way in relation to other participants.

It was for this reason than I became preoccupied with the question of leadership and being seen as a "teacher" in the group. According to Reason, taking on the function of democratic leadership, or teacher with an educative and/or facilitative role is an acceptable and legitimate way of ensuring *"effective group working"* (1988:27 ibid). Yet while he accepts this as functional for the research process, its implications in terms of the exercise of power that such roles embody is unexplored. Rather he assumes that these functions may be maintained within the control of the group who may re-negotiate different roles at a later stage in the inquiry, if necessary. My concern was how far others in the group could control the process, if they wanted to.

1.2 Control

In my account of Group 1 (chapter three) I expressed concern that the students too readily accepted my suggestions, were apparently unwilling or unable to contest what was discussed, and were too easily guided in directions I might choose to lead them. By contrast in Group 2, (chapter four) increasingly it seemed that they were less easy to direct and less willing even to carry out tasks that they had agreed to undertake (eg. writing about significant events, completing the pro forma for discussing the report). So what was different about these two groups and my place within them?

It seemed that Group 1 valued the opportunity to meet in order to construct accounts of what becoming a midwife could mean to them. The inquiry provided them with a space that they did not otherwise have, when they could share ideas and talk about their experiences. They worked at three separate hospital sites and had few other opportunities, particularly as their course progressed, to exchange views. Four students here exited from the inquiry, three because they left the course but a fourth because she was unwilling to participate on the terms that had been agreed (chapter three conclusions). Apparently unable to exert control over the process this student chose to leave the group and as a result had no 'voice' within it. She

appeared to violate the central premise on which group inquiry was set up - that participants would be willing to enter into a ***dialogue*** and contribute to a discussion that would work towards reaching agreement. By refusing to speak in the group, because she had no wish to share her views (or to have them recorded), this student was silenced and exercised control by opting out of the process. Subsequently three more students left the inquiry though their reasons for leaving were unclear. However those that remained were committed to seeing it through and in the process found their voice as a group (see chapter three, workshop 4). The terms of their participation in the inquiry were shaped by the specific institutional setting and a continuing interest in defining themselves as 'becoming midwives'.

For the other group (Group 2) participation in the inquiry became something they did for me, rather than for themselves.[6] The circumstances of their involvement were different in that they told me they had plenty of other opportunities to discuss their views, that often what we talked about in the inquiry repeated earlier discussions they had. Moreover, as they became increasingly disaffected by their experiences of becoming a midwife, so they appeared to withdraw from the inquiry. They became less energetic in the debates and, as they put it, *"half-hearted"* about their participation in this research. It was as if their increased despondency about midwifery practice, and dissipation of their anger, was mirrored in the inquiry process. Yet by resisting a more pro-active form of participation, by not taking initiative in what the workshops covered or how they were conducted, in effect, they increased their control over the inquiry process. While I felt increasingly out of control, on the outside, looking in (chapter four, GI2 w4, w6).

My place within the two groups could be described in different ways, for as Maguire says, there are a number of roles which can be adopted and, during the inquiry, it is possible to move between them. She describes the difficulties this gives rise to:

" I had great difficulty juggling the demands of the participatory researcher roles of researcher, educator and organizer. At times, the roles appeared to be in conflict. For example, in the organizer role, I motivated women to attend meetings, and to increasingly participate in decision-making,

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6 This does raise the question "who was the research really for?"The continued participation of students in both groups suggests that they did perceive it to have some benefit. Some might have said it was for me (GI2 w4) while others, particularly in Group 1, felt that it had served a useful purpose for them (GI1 w3).

discussions and group actions. Yet, I often questioned this role. By motivating women, was I trying to make the project, my dissertation, a success? As researcher, I felt the need to step back and see what would happen when I did not play the motivator role. It was confusing at times to balance somewhat conflicting roles.

Self-censorship was a problem. Afraid of being pushy, overbearing, intimidating, or culturally inappropriate, I initially refrained from utilizing many trainer skills, techniques, and exercises which would have contributed to group skill development. I struggled with the educator role. No one in the group asked to explore structural analyses of racism, sexism, or classism. In that sense conscientization was my agenda not theirs" (Maguire, 1986:189).

She says transferring control to participants was a major difficulty but concludes that others in the group did not have the skills to perform certain tasks (eg. leadership) or they did not want to do these things. Although I aimed to be flexible in my approach and, like Maguire, I was anxious not to be over directive, I also felt increasingly that 'I had to be my self', that not only was this a more honest thing to do (morally defensible), but it became the only way I could operate. It was not possible to 'bracket off' my knowledge and skills, my participation in the process made sense only in terms of my ability to construct an account of who I was and what I was doing there.[7] In the two groups I contributed in different ways and in Group 1 I felt that they wanted to me to take the lead, to structure the meetings and that this was functional for the group. In Group 2, when they did not want to follow my suggestions, we talked about other things or approached the meeting in a different way. So, for example, when they had not prepared written accounts as agreed, I suggested that instead we use the time to generate those accounts, to think about what they might include and then they could send them to me (GI2 w2). The confusion and ambiguity portrayed by Maguire's and my own account of the process, relates to a confusion about the implications of inequalities in the group and a concern to adopt a procedure that is just and fair. Such concerns are central to notions of an 'ideal speech situation' which I will now discuss.

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7 There did remain difficulties about how other information collected as part of the evaluation project, and indeed experience of working with two groups, affected my participation. I could not deny that I had other information, only explain that I was not at liberty to share it. Certainly, both groups wanted to know more about each other and were disappointed that I felt unable to discuss this. My strategy for responding to this was to suggest that they could contact any other students if they wished and I could provide them with a list of courses around the country since this was already in the public domain.

1.3 Justice and fairness

In order to assess the achievements and issues raised by group inquiry as a form of participatory research I find it useful to draw on the work of Seyla Benhabib. For her analysis of contemporary ethics in *"Situating the Self"* provides valuable insights and a feminist revision of Habermas' work and seems to draw together a number of threads running through this thesis. Although she does not talk directly about research I see her approach as particularly useful for discussing group inquiry. She pleads

"for a radically proceduralist model of the public sphere, neither the scope nor the agenda of which can be limited a priori, and whose lines can be redrawn by the participants in the conversation. Habermas's concept of a public sphere embodying the principles of a discourse ethics is (her) model" (Benhabib,1992:12).

Following Habermas, she outlines a revised procedural model of the public sphere that is

"an actual dialogue among actual selves who are both 'generalised others', considered as equal moral agents, and 'concrete others', that is individuals with irreducible differences" (Benhabib,1992:169).

A closer look at her work will help to clarify the confusion surrounding group inquiry and legitimate the view that it is both politically and morally unnecessary to suggest that we need to become disengaged and disinterested participants in research. Instead, it is precisely as ***embodied*** selves, or ***interested*** persons that we are enabled to participate in a democratic process that is both just and fair.

In so far then as democratic **procedures** characterise group inquiry (or feminist participatory research) the rationality of the procedure, according to Benhabib, is of philosophical interest and the principle of modernity is *'the unlimited and universally accessible participation of all in the consensual generation of the principles to govern public life"* (Benhabib, 1992:81). Group inquiry, as a form of participatory research, is then underpinned by certain modernist principles and the aim of reaching an agreement is premised on a model of participatory politics that is **rationalist**. Benhabib, however, distinguishes between the liberal (Kantian) view of public space, that views participants as unencumbered, free thinking individuals (the universal subject), from Habermas' discursive view - a discourse model of legitimacy, a politics of communicative ethics (for a brief overview of this

model see Habermas 1994). She explains how according to the discourse model, participation becomes redefined as *"discursive will formation"*. Participation is extended to include the realms of society, personality and culture (Benhabib,1992). Participation entails the generation of consensual *"norms of actions""*, a reflexive process of self-definition, and the creative appropriation of meaning (see also Giddens 1991). Habermas' idea of *"practical discourse"* therefore draws attention to the conditions for participation and the constraints on how debate is conducted. Benhabib specifies these conditions (for an "ideal speech situation") as ***"universal moral respect"*** and ***"egalitarian reciprocity"***.[8] However, within these rules for debate, the possibility of contesting the rules themselves remains so that

"in democratic politics nothing is really off the agenda of public debate, but there are fundamental rules of discourse which are both constitutive and regulatory in such a manner that, although what they mean for democratic give and take is itself always contested, the rules themselves cannot be suspended or abrogated by simple majoritarian procedures" (Benhabib 1992:107).

So there are no limits to what may be discussed or debated and even the rules for debate may be contested within the terms of those rules (ie moral reflexivity). According to Benhabib, it follows that communicative ethics *"trumps"* other ways of ordering public life and, while not morally neutral, it is more rational for it enables 'validity claims'[9] to be justified. To what extent then were these conditions fulfilled in group inquiry? How, in practice could universal moral respect and egalitarian reciprocity be demonstrated? And how does this discourse model reframe ways of knowing, understanding and being in the world?

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8 1. Universal moral respect : *"we recognise the right of all beings capable of speech and actions to be paricpants in the moral conversation:" 2. these conditions further stipulate that within such conversations each has the same symmetirical rights to various speech acts, to initate new topics, to ask for relfection about the presupposions of the conversation "* (Benhabib 1992:29) ie the principle of egalitarian reciprocity.

9 For an elaboration of 'validity claims' see White (1988). He explains *"When a speaker orients himself toward understanding - that is, engages in communicative action- his speech acts must raise, and he must be accountable for, three rationality or "validity claims" : truth, normative legitimacy and truthfulness/authenticity. Only if a speaker i s able to convince his hearers that his claims are raitonal and thus worthy of recognition can there develop a "rationally motivated agreement" or consensus on how to coordinate future actions" (p28).*

2.0 Rationality and relativism - discourse, knowledge and ideology.

In chapter two I outlined the ascendancy of scientific rationality in the modern world and subsequent critiques of this from both sociologists of science, feminists and postmodernists. My purpose was to locate this thesis and group inquiry within the context of a sociology of knowledge that recognises the challenge that those criticisms represent. In particular, I introduced the idea of a participatory universe and holistic knowing as a way of integrating experiential, propositional and practical knowledge. My account of group inquiry points to the difficulties this presented to me. For I was left wondering what the relationship between these ways of knowing might be. The students' ***experience*** of becoming midwives was a primary focus of the inquiry, but so too was the experience of face to face interaction within the group, our work as 'co-researchers'. Yet by recognising that ***propositional knowledge*** or theory might also have an important place in the group, I was uncertain about whether this was to be generated from these experiences as in 'grounded theory' (Glaser & Strauss 1967) or whether sociological theory, or at least my knowledge of it, could legitimately be included in our discussions (especially given the criticism of 'grand narratives'). Finally, as already indicated, the ***practical skills*** necessary to carry out the research, and to undertake midwifery practice, were unevenly distributed in the two groups.

Rejecting any suggestion that there is necessarily a hierarchy of knowledge I had to admit that the status of different ways of knowing and being in the world are unequal. Like other participatory researchers, I sought to validate the students' experiences, to accept these as a justifiable and an acceptable basis for a claim to knowledge. At the same time I suggested to them that we needed to go beyond our subjective views, to generate an explanation of those experiences and a critical understanding of the everyday, taken for granted aspects of daily life, to develop *"critical subjectivity"* (Reason, 1988ibid). This was not easy and while Maguire admitted (above) that her agenda was conscientization, mine was to articulate experience and theory against each other as Heron (1988) (and Stanley & Wise, 1993) suggest. Trying not to prioritise either sociological accounts of student life or midwifery practice, or the students' own accounts, the meetings were intended as a dialogue between us so that we could draw on a range of possible explanations and reach some kind of agreement about what we would accept as legitimate. It seems, therefore, that as a form of

dialogical inquiry a better understanding of discourse as a theory of knowledge was needed by me and it was this that seemed to be missing from the work of Reason, Maguire and other participatory researchers, though Heron (1981) does point to the importance of language in generating understanding and mediating experience.[10] My emphasis then is on meaning as ***negotiated*** and language as social and political practice.

2.1 Knowledge claims

So far, I have signalled my awareness of how language has been used by scientists to represent the 'facts' about an object world and how, following 'a crisis in representation' the ideological function of this as a means of obscuring the relationship between knower and known has been criticised by Woolgar and others. Consequently, the focus has shifted to *"the discourse of science"* and how it sustains a particular **"moral order** *of relationships between agents of representation, technologies of representation and their represented objects"* (Woolgar, 1988:14 ibid emphasis added). In other words how scientists sustain and legitimise ***authoritative*** claims to knowledge. Woolgar ***relativises*** the accounts of scientists by arguing that their social position enables them to produce and validate their accounts, but that other accounts are possible, that all knowledge is contingent, including that of the sociologist, and there is no independent position from which the "truth" status of knowledge claims may be judged. The charge of relativism is one that postmodern writers face and Foucault's reference to *'regimes of truth"* emphasises the multiplicity of accounts and discursive practices as constructing both subject and object. For according to this view of the world, the subject, or knower, is not fixed but is constantly being created and recreated through language.

This led to the strong criticism by Stanley and other feminists that postmodernism undermines feminist projects, by denying the category of 'woman' as meaningful and rendering the oppressive consequences of gendered knowledge as insignificant. Arguing for *"a fractured foundationalism"* Stanley sought to reassert the ontological priority of

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10 For a useful discussion of dialogic methods see Gergen (1989). In *Talking about Menopause* Mary Gergen describes her use of dialogic method as consistent with feminist ideas of research which is intersubjective, participatory and emancipatory. Her identification of these as central concepts is similar to the three central themes I have identified above in chapter two.

women's experiences and the importance of recognising them as material beings, as ***embodied***. This could however, be seen as a reassertion of identity politics, excluding other groups and policing boundaries. In contrast feminists such as Hennessey (1993) and Ferguson (1993) argue that the possibility of effective political strategy is strengthened by the view that subjectivity is *"mobile"* and coalition politics, which recognises a plurality of experiences and positions, provides a way for differences to become the basis from which to negotiate agreement and take action. It is this acceptance of plurality, and celebration of difference that attracts the charge of liberalism or even conservatism against postmodernists, but, by returning to Benhabib's revision of the discourse model of legitimacy, I find further purchase on these debates.

2.2 A Discourse model of legitimacy

In her analysis of *"the end of the episteme of representation"* Seyla Benhabib identifies three critiques of the Enlightenment model:

1. A critique of the modern epistemic subject
2. A critique of the modern epistemic object
3. A critique of the modern concept of the sign

She explains how the substitution of the self as an active agent *'creating conditions of objectivity by forming nature through its own historical activity"* is central to the tradition of German idealism expressed in the work of Marx, Freud, Horkheimer and Habermas' early work (in Knowledge and Human Interests 1979). While the self was not seen as fully autonomous, the emancipatory project was to render conscious those hidden desires and needs. The second critique drew attention to the ways in which *"the concept, the very unit of thought in the western tradition ...imposes homogeneity and identity upon the heterogeneity of material"* and created a world of 'things' or bounded objects, ie *"the triumph.of western ratio"* (Benhabib, 1992: 208). While lastly a critique of the sign calls into question the view that there exists a natural relationship (correspondence) between the sign and the signified and instead proposed that systems of social relations determined what signs could stand for.

With reference to these three criticisms of the Enlightenment model Benhabib maintains that Lyotard and other postmodernists focus primarily on the critique of the sign and that they lead us to accept a *"polytheism of values"* and a politics of justice beyond consensus. In their view, she

claims, there is no longer a subject - therefore epistemology and the philosophical project is finished - and by rejecting Cartesian dualism there is no independent position from which to judge knowledge claims, only diverse voices that compete to be heard. By contrast, in advocating

"a fallibalistic and procedural concept of rationality and the normative options allowed by this in ethics and politics" (Benhabib, 1992:210)

Seyla Benhabib provides some basis on which the acceptability of claims may be judged. This ***procedural rationality*** and Habermas' communicative ethics are ***universal*** principles which we mobilise in order to allow diverse voices to speak, and divergent views to be expressed, so that political strategy and action may be advanced. What is presented here, by Benhabib, is a model that incorporates the three critiques, that enables us to understand communication as action (ie. practical discourse) and to acknowledge the ontological priority of material beings in a material world. By rejecting the relativist position Habermas and Benhabib show us a way of being in the world, knowing and changing it, that significantly, allows the criticisms of the Enlightenment model to be upheld and also the project of modernity to continue.

According to this model of communicative action, the normative basis of speech is emphasised. In other words, to speak, according to Habermas, is to act[11] and through speech, agents make inherently moral assumptions which may be universally applied. White explains

"in ongoing communicative action, subjects coordinate their behaviour on the basis of mutual recognition of validity claims. This reciprocal recognition does not necessarily rest on the actual testing of a specific claim, but rather on the basis of a supposition by the hearer of the speaker's accountability. This reciprocal supposition of accountability involves two expectations: that the other's actions are intentional and that he (sic) *could, if called upon, justify the claims he raises in interaction"* (White, 1988:50).

This *"speech-act-immanent obligation"* says White *"is one which every actor has 'implicity recognised', simply by virtue of having engaged in comunicative action"* (White, 1988:51).While this obligation is insufficient to sort out types of ethical position, discursive rules are necessary for the achievement of a rationally motivated agreement, rules that are not externally imposed but are presupposed by agents who make normative (ie rational)

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11 Speech-act theory is usually attributed to Austin (1962) see Potter & Wetherell, (1987), Habermas, (1984) and Thompson (1984).

claims, says White (1988). Where agreement that "generalises interests" is not possible, compromises are necessary. For these to be legitimate, for example where unequal bargaining positions exist, the burden of proof is on the advantaged agent to justify inequalities.

Discourse theorists such as Foucault describe a world where diverse groups may be seen as talking past each other, speaking in different, though shared, languages, with little point of contact and no basis for dialogue. The Habermasian model, in contrast, sets out the grounds and conditions for dialogue, the circumstances under which different points of view may be articulated and agreement reached.[12] But Tyler (1991) argues that modernism teaches

"the terror of consensus.....that it both presupposes and makes its goal the creation of a consensual community of discourse which is a sensus of ens CONstituted by the DISCIPLINE of method, the technology of agreement in judgements. CON-sensus is the technology of representation, of the vote within the CON-munity of the elect that says 'this is so because we say so' The great end of all consensus is to bring discourse to an end in the silence of agreement, in the elimination of difference, and the reduction of all opposing voices to a single disembodied voice that having spoken in the authority of all falls silent. Consensus is the technology of the fascism of science, democracy and bureaucracy" (Tyler 1991:82).

Consensus here is seen as a CON, an ideological process that obscures and elides difference, silencing voices and controlling persons. However, Benhabib distinguishes between 'consensus' as conventionally understood, from generating an agreement through argumentation and debate. In her view, rather than this closing off further debate, or the conversation ending, there is a possibility of it continuing ad infinitum where there is the political will to do so. This Habermasian position, according to Benhabib is distinguishable from classical liberalism and from relativism or nihilism because it provides a way forward, by bringing forth order from chaos and allowing it to change, then to be revised again. It is not that consensus or agreement necessarily ends the discussion but, for practical purposes, it enables us to proceed. And though Tyler maintains that this subsumes differences in a quest for *"totalisation"* , Benhabib outlines a way in which there can be unity in diversity, where differences and a willingness to take the view of the 'other' does not lead to uniformity, where autonomy and

12 For a critical assessment of Habermas' work see Thompson (1984).

solidarity are two sides of the same coin, mediated by discourse, and where 'facts' and values are reintegrated through a process of moral justification.

2.3 Beyond method

In group inquiry I was faced with these ideological dilemmas. How could the different experiences, and views of participants be accounted for? On the one hand I could take the role of analyst and examine the variability between individual accounts, looking for the ways in which these were structured, the discursive rules that were played out in the way students told their stories - a discourse analytic approach. But would this not set my interpretation above theirs? How could I justify my position as analyst?[13] What values were intertwined with the 'facts' of 'becoming a midwife'? How could I ensure that I was accountable to them - that my account was subjected to scrutiny and dispute by them? For as analyst I could appear to have the last word. Although Woolgar, Ashmore and other reflexive discourse analysts do not set stable boundaries around their research accounts, but seek to open them up, to invite dispute (by using new literary forms), I wanted to invite the students to dispute my view, to be accountable to them for the claims that I might make and this seemed possible only within the confines of face to face dialogue- as actual selves in actual dialogue.

Accountability was important in order that we could arbitrate between different accounts or validity claims. It seemed that only then could claims to 'know' what becoming a midwife might mean, be legitimated. A discourse model of legitimacy is useful so that the authoring of a research account is not seen as an exercise of power, that knowledge produced is not the product of exploitative and oppressive social relations, the control of one over an'other'. In short, group inquiry was seen as a method that could potentially, give voice to differences, but that could also recognise common concerns. It was not intended as a means of control but as a procedure where communicative rationality

"carries with it connotations based on the central experience of the unconstrained unifying consensus-bringing force of argumentative speech, in which different participants overcome their merely subjective views and,

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13 See Fairclough (1989) for suggestions on this point in relation to discourse analysis.

owing to the mutuality of rationally motivated conviction, assure themselves of both the unity of the objective world and the intersubjectivity of their lifeworld" (Habermas in White 1988:43).
Through dialogue we could therefore construct narratives of 'ourselves' as participants in the research and as authoring accounts of 'becoming a midwife' via programmes of pre-registration midwifery education.

According to Tyler,
"TRUTH, in modernism, is subborned by METHOD. Truth is only the means of production, what those who do it right say it is. METHOD, the technology of truth, the rational means that make truth, relativizes truth not to time, place, or purpose, but to its instrumentality. Method is the ritual that brings forth the true. It is the enactment of correct, approved procedure, and disagreement about truth can only be disagreement about whether or not proper procedures were enacted in its calculation" (Tyler, 1991:85).
So can we go beyond method and abandon 'truth' altogether? Criticisms of modernist concerns with 'truth' are premised on the belief that there are normative constraints on what will be accepted as a 'true' account of the world. In other words, that certain other accounts are rendered 'false' and the supremacy of one claim to truth over another can only be disputed by challenging the method, rather than the position of the knower. It follows that this position remains unaccounted for, uncontested and intact. While counter claims to 'know' may be put forward on the basis of other "standpoints" (eg feminist standpoint theory) this can lead to a situation where 'truth' is read off from experience, or the social position of the knower. What is then highlighted is <u>who</u> knows and attention focused reflexively on the position of knower and circumstances of knowing. Yet, if there can be no agreed position from which to judge claims to know or the 'facts' of the case, does anything go? Are all comers accepted as having a legitimate or valid claim? It is this effect that critics of epistemological relativism and much postmodern writing argue leads to charges of moral bankruptcy. For, in practice, we do adopt value positions in order to judge the adequacy of accounts and it is a procedure for enabling us to discern between these value positions that Habermas and Benhabib advocate.

At the level of research practice this amounts to an exhortation to adopt an ethical position that enables participants in the research to have the opportunity to validate their claims to 'know' as morally justifiable and, more radically, to set the terms/rules under which such judgements will be

made. So, in order to arbitrate between accounts, any dispute is reframed as a question of moral principles and political practice, rather than an epistemological debate about the relationship between knower and known (subject and object). The terms of a debate about 'truth', then, may be adjusted as we discard worries about the stability of the subject and object world and how we may know ourselves. Instead, the creative possibilities of negotiating who we are and how to act in the world extend before us through engagement with others. The will to enter into this dialogue is the will to become a person, to define a 'self' and to make sense of (know) our place in a world shared with others. That is not to suggest that an agreement provides any kind of ontological guarantee but it can provide a direction in which to proceed.

3.0 Emancipation - a modernist project

Participatory researchers claim that research with and for people, rather than on them, has an emancipatory potential (Maguire, 1987; Reason, 1988). Knowledge produced in this way is expected to empower and enable participants to gain a better understanding of their lives, or the issues raised, and to take action that may enhance the quality of their lives or address problems identified. As a form of 'action research' these researchers explicitly aim to bring about change informed by the research and action may be seen as part of the inquiry process, a dialectical research cycle (Rowan, 1981). Rowan describe this as *"a dialectical engagement with the world"* starting from experience, from *"BEING"* . Then, by turning *"against old ways of doing things"* moving inwards and outwards through processes of *THINKING*, and *MAKING SENSE,* involving others in the *PROJECT* and by *ENCOUNTER* with them, *COMMUNICATION* of new ideas and new ways of being are developed (see also Rowan in Reason 1988). Change is understood by Maguire(1987 ibid) and others as both a personal and social process of transformation that challenges existing social structures and leads to personal growth, where through "conscientization" liberation may occur (Friere, 1970). If everyone sees the value in participation and wants to be liberated, participatory research, in generating knowledge that is with and for people, rather than on them, provides a means of agreeing what action is to be taken.

Giddens (1991) sees emancipatory politics as characteristic of modern society and having two main elements: *"the effort to shed shackles of the past, thereby permitting a transformative attitude towards the future; and the aim of overcoming the illegitimate domination of some individuals or groups by others"* (1991:211) He says the objectives are *"either to release underprivileged groups from their unhappy condition, or to eliminate the relative differences between them"*. This emancipatory agenda is *"a politics of 'others'"* focusing on differences and divisions within society, aiming *"to reduce exploitation, inequality and oppression"* by promoting justice, equality and participation (Giddens, 1991:211-212). To what extent then could group inquiry be seen as having an emancipatory agenda or an emancipatory potential that was (or could) be realised? In what ways does a politics of difference inform an understanding of the inquiry process and how might there be unity in diversity? And, finally, what kind of utopian dream underpinned this inquiry?

3.1 A Politics of difference

When exploring aspects of the current debate between feminist supporters and critics of postmodernist writings in chapter two, it became evident that a politics of difference was of central concern, where emphasising differences was an important political tactic. It seemed that for some feminists an oppositional political strategy that sought to free women from oppression was contingent on the valuing of the category 'woman'. This could be seen as both inclusive and exclusive in that, for Stanley & Wise (1990, 1993) recognising differences between women, did not signal an abandonment of 'woman' as a important basis for political action. For them *"fractured foundationalism"* provided both a foundation of women's experiences, from which to generate knowledge for action, and at the same time encompassed differences between women (ie. within the category woman) . Moreover this was not intended to deny that 'woman' is a social construct, constructed through the discursive ordering of social and political life and they supported the view that identities are constantly being created and are 'fractured' rather fixed and unitary. They were, however, critical of the notion that politics might be reduced to a series of language games which they inferred from much postmodernist writing.

In contrast feminist supporters of postmodern writings sought to shift the emphasis away from identity politics and questions of who am I? to what can we do? and argued for a coalition politics based on a coming together of divergent interests to *"speak from a counter-hegemonic collective subject"* (Hennessey 1993). For Hennessey, Ferguson (1993) and Hekman (1990) feminist rejections of Cartesian dualism and the epistemological foundations of Enlightenment humanism (the universal, male, rational subject) necessarily implies a realignment of feminism with postmodernism and relinquishing all aspects of the modernist project - but is this really necessary? Or is a revised project for feminists in a modern world a viable option?

In group inquiry I began with an agenda that was to work with women to produce knowledge that was for women. As such this was explicitly a feminist emancipatory agenda for I was interested in explicating the ways in which students on pre-registration midwifery courses, made sense of 'becoming a midwife'. Through developing a critical understanding of midwifery politics I hoped, with the student groups, to illuminate the processes whereby they constructed themselves as 'midwives'. I

understood this as an ideological process where they would weave their own accounts of being midwives from the dominant and sometimes contradictory meanings available to them. Midwifery discourse, including the language of 'health' and 'empowerment' was appropriated by them as they articulated their views of the educational programme and the aims of professional midwifery practice. Through the process of dialogical inquiry I saw myself as siding with them, positioning myself in such a way that we could explore what becoming a midwife meant, together.

In a discussion of interviewing Oakley (1992) refers to work by Finch (1984) who said, *"the 'siding with' the subject that is characteristic of feminist interviewing is entirely consistent with major traditions in sociological research in which.....the sociologist sides with the underdog".*
Oakley continues *" But the essential difference is that a feminist researcher doing research (on) women shares the powerless position of those she researches; this carries the corollary of an emotional as well as an intellectual commitment to promoting those interests.*
For, as Finch asks *"How else can one justify having taken from them the very private information which may have been given so readily?"*
According to Oakley, Finch is more comfortable with the aim of creating *"a sociology for women rather than of women"* '(Oakley 1992:16). This view, that by virtue of shared experiences of powerlessness, women researchers are able to position themselves alongside women they interview, does not explore other differences that may have significance (eg. class, age, education etc).[14] What is mobilised here is the idea that feminist knowledge rests on ***shared experiences***, and that a collective consciousness arises from the shared experiences of oppression. This has relevance for group inquiry.

The assumption that a collective consciousness arises from shared experiences presupposes that solidarity is contingent on ***sameness.*** That sameness, in this example, being women, is the essential feature of oppositional strategies and emancipatory politics. Yet there are clearly *"irreducible differences"* (Benhabib, 1992) between groups of women that transect each other. Current debate between feminists seems therefore to

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14 It is precisely this siding with the underdog that I was criticised for by the research manager at the DoH -see letter in appendix 20.

place varying emphasis on the significance of differences and similarities. This is a fruitless and rather destructive debate and does little to clarify for me the inquiry process. For I could not fully share the students' experiences of 'becoming midwives', I was not a student on the course and in this respect there was indeed an irreducible difference. I was an outsider, looking in (chapter four). There were also, as I have already indicated, other differences between the students (eg. age). At the same time however there were important similarities - we were all women, although not a midwife, I had trained and worked as a nurse in the health service (though of course as a nurse I was set apart from them); some group members were similar in age and some students, like me, had a university education. Similarities and differences co-existed. What had been misleading for me was the implicit acceptance of concepts of justice and equality which imply sameness (Richter, 1991). A view shared by Giddens (ibid) who sees the elimination of relative differences as a primary purpose of emancipation. In other words this is a view that accepts norms of justice and equality that are themselves gendered. By returning once again to Seyla Benhabib's work I find that there is a possibility of a revised, feminist modernist project where solidarity is understood in terms of reciprocity (see also Tronto 1993).

3.2 Taking the view of the 'other'

In arguing for a revised, Habermasian model of discourse, Benhabib maintains that Habermas exhibits the rationalistic biases and exclusive justice orientation of earlier moral theorists. He distinguishes between justice/good life, norms/values, needs/interests in such a way that he restricts his definition of the moral domain to issues of justice. She aims to enlarge his model by feminising practical discourse which she believes will advance the emancipatory aims of new social movements such as feminism. The work of Carol Gilligan (1982) is seen by her as offering important insights into how this *"enlarged mentality"* can be achieved.

Following Gilligan, the tendency for women to take on the standpoint of the particular other in making moral judgements highlights the importance of contextualising these judgements. This, says Benhabib, means going beyond the *"substitutionalist"* moral theories of the western tradition which take the experiences of one group to stand for everyone (the universalism of white, male, bourgeois ideology), to *"interactive universalism"* which begins from recognising plurality and difference, *"without endorsing all*

these pluralities and differences as morally and politically valid" (Benhabib, 1992:153). Then

"'universality' is a regulative ideal that does not deny our embodied and embedded identity, but aims at developing moral attitudes and encouraging political transformations that can yield a point of view acceptable to all. Universality is not the ideal consensus of fictitiously defined selves, but the concrete process in politics and morals of the struggle of concrete, embodied selves, striving for autonomy" (Benhabib, 1992:153).

While the former model silences the voice of the 'other', the interactive model allows 'others' to speak. In other words, diverse, embodied, actual selves come together in actual dialogue, to reach agreement and those very differences provide a basis from which negotiation and bargaining can take place. According to this model rather than being expected to render differences invisible behind a Rawlsian 'veil of ignorance' and assume that everyone is equal (ie the same), the capacity to participate in debate is seen as flowing from the 'concrete experiences' of 'actual selves'. For, says Benhabib, behind a 'veil of ignorance' there is an undifferentiated, *"generalised other"* and no possibility of distinguishing between interests or taking the view of the *"concrete other"*. So, by acknowledging differences, and taking the view of the other debate may be opened up (enlarged) to include the desires and needs interpretations of 'others' for *"only a moral dialogue that is truly open and reflexive and that does not function with unnecessary epistemic limitations can lead to a mutual understanding of 'otherness'"* (Benhabib, 1992:168).

By adopting Benhabib's model it seems possible that in group inquiry an agreement was reached that was acceptable to all, but did not deny differences within the group . Moreover, by recognising those differences, reflexively, an emancipatory potential could be realised. Since the purpose of the inquiry was, through actual dialogue, to give voice to different views in order to reach a consensus about what the issues were, it can be argued, on moral grounds, that the agreement reached is not a CON as Tyler (1991) would maintain. In seeking to make myself accountable to the group, I could acknowledge (rather than deny) my own position of power but also take the view of the 'others' when writing accounts of 'becoming a midwife' and taking part in the inquiry. In this way unity in diversity could become practically possible and part of a political strategy of coalition politics. Reaching an agreement does not imply that the conversation must necessarily end, that certainty and closure has occurred, but it does provide

a basis of further action and dialogue. Through the inquiry process itself I was able to adopt the ethics of justice and rights, and of care and responsibility, [15]to express solidarity with two relatively powerless groups of students who were encouraged to exercise the right to speak about their views of pre-registration midwifery education in England.

3.3 "From Utopia to Reality"[16]

Throughout my discussion of group inquiry, and following this detailed look at Benhabib's work I have constantly asked myself what kind of guarantees a democratic approach to evaluation and research might provide. Can we assume that a democratic research ***procedure***, will necessarily promote social justice? How could I be certain that the views of the student midwives would be heard, that group inquiry, which explicitly adopts a model of participatory politics, would be effective if, in order to be effective, the emancipatory agenda of the inquiry had to be realised? What utopian ideals were implicit in these concerns?

I suggested at the beginning of this thesis that the inquiry offered me a number of opportunities. The chance to explore the relationship between knowledge and power and to construct accounts of becoming a midwife via pre-registration midwifery programmes of education. It was also an opportunity to construct accounts of my self as a woman sociologist, to construct my own identity as author of the thesis and to come to a new understanding of how knowledge is produced. In the same way that the student midwives hoped to empower themselves as professional midwives, in order to empower women they worked with, I too hoped to empower myself through working with them. Recognising that the emancipation of women during childbirth was intimately tied up with their professional power as midwives, I came to recognise how their emancipation was intimately tied up with my position and power as a sociologist. This symmetry may be understood in terms of the interactive, discourse model I have used in my analysis. For,

"a coherent sense of self is attained with the successful integration of autonomy and solidarity, or with the right mix of justice and care. Justice

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15 See also Tronto (1993) above in chapter five section 3.3.

16 This was the title of the first national RCM Education conference held in 1993.

and autonomy cannot sustain and nourish that web of narratives in which human being's sense of selfhood unfolds; but solidarity and care alone cannot raise the self to the level not only of being the subject but also the author of a coherent life-story" (Benhabib, 1992:198).

Coherence of life-stories may be conceived of *"as narrative unity"* (Benhabib, 1992:198) where the lives of one are intertwined with the lives of 'others' and depends on our ability to tell our story from the perspective of 'others' and from the standpoint of the individual (see also Stanley 1993). For the students, becoming a midwife could be understood as both a personal transformation and a social process which would enable them to side with 'other' women. For me becoming a sociologist was both a personal process and one that enabled me to side with them.

Heron puts it another way, saying that through the inquiry process there is a coming together of propositional, experiential and practical knowledge which enables the participants to act together.

"In a co-operative inquiry the propositional knowledge asserted by the research conclusions is coherent with the experiential knowledge of the researchers as co-subjects, and their experiential knowledge is coherent with their practical knowledge in knowing how to act together in their researched world" (Heron 1988:42).

However, he says that *"action in the researched world may lie beyond the confines of the inquiry,in the future"*[17] and in this case inquiries may be considered *"provisionally valid"*. In such cases coherence with experience becomes the criteria of validity and the test of 'coherence' is consistency of research conclusions and agreement between inquirers. So the validity of the inquiry can, according to this view, be evaluated on two levels, at the level of experience and agreement about those experiences. A test of the coherence of this inquiry then is the extent of agreement about the reports produced and presented in chapters three and four. One student, while largely agreeing with the report felt that it did not truly represent her view or experience of the inquiry (see appendix 19). Some group members were very supportive of the report and others seemed to defer to it. Was this inquiry then "provisionally valid"? Heron says

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17 For Heron 'coherence' has three components- " the researchers' explicit, formal statements,; the tacit, propositional constructs within experience,; and the persentational constructs within experiecne". For covenience he refers to these as "three kinds of construed world : the researched world, the posited world and the presented world" (Heron 1988:41).

"Validity is enhanced by a diversity of views that overlap. It is not found simply in the common properties of the different views, but rather in the unity-in-variety of these views. Agreement of this sort cannot be absolute, at any rate so far as coherence with experience is concerned, and in the early stages of developing the researched world. It admits of degrees. It is a matter of judgement when the degree of agreement is so low that it constitutes a criterion of inadmissible disagreement...." (Heron, 1988:44).

While experience, mediated by language, provides both a basis from which to generate agreement and an empirical test of that agreement, the unity of narrative, or the telling of a story it could be argued, does not of itself have a transformative capacity. After all, in what sense does to speak mean to act? Habermas' theory of communicative action, revised by Benhabib, does provide an important view of how we need to shift from a theory of consciousness that prioritises 'experience' to a theory of language that allows us to understand how it is discursively constructed. While this does not lead to the prioritising of 'language games' (as some postmodernists might argue) it does provide us with some guidelines for arbitrating between competing accounts of 'reality' (experience). The justification of accounts (validity claims) is supported on moral grounds that can inform political practice. Even though this does not provide any guarantee of social justice, it does ensure that the voices of different groups will be heard. Moreover, according to Benhabib's revised model, competing interests may be articulated and debate may be enlarged to include discussion about what the good life might be . Rather then than pre-supposing that there is a utopian vision that would be acceptable to all (ie a totalising one) I prefer to encourage the dialogue to continue, to see all agreements as provisional. In the case of the group inquiry report, which was included in the evaluation report to the Department of Health (Kent et al, 1994), the potential for students to influence national debate may yet be realised. It will however be mediated by the views of others represented in the evaluation report. It would be foolish for me to attempt to predict what the outcome of that debate might be but I recognise that it is one that should be conducted with the widest consultation and that it will take place in the context of other discussions about the role of the midwife in the future (eg DoH 1993). I do not believe that this amounts to a retreat from utopia and agree with Benhabib that we need to keep alive such a vision *"for we as women, have much to lose by giving up the utopian hope in the wholly other"* (Benhabib, 1992:230). By being 'with women' in this 'reflexive project' I have been

able to weave the stories of becoming a midwife with those of becoming my 'self', to find new ways of speaking and writing about how each of our lives connects with the lives of 'others'.

CONCLUSION

In this final chapter I have explored the issues raised by inquiring together. I have argued that, as a form of feminist participatory research, through *group inquiry* I have gained important insights into the relationship between knowledge and power, democracy and truth. By adopting a discourse theory of knowledge and a radically procedural model of rationality proposed by Seyla Benhabib, I have shown how a discourse model of legitimacy has relevance for participatory researchers. While previous researchers have referred to participatory research as *dialogical inquiry,* the implications of this appeared under explored. Benhabib's work, by revising the ideas of Habermas in the light of feminist theory, provided a way of assessing the achievements and shortcomings of group inquiry method.

Specifically I have been able to rethink the significance of differences between participants in this inquiry. While previous accounts of participatory research seemed to gloss over such differences and assume that inequalities within each inquiry group could be set aside, I have now shown how those very differences must be seen as part of the dialogue that takes place. That is not to say that those differences are fixed or that knowledge is foundational, rather that, through dialogue, identities are co-constructed and may be articulated in the process of negotiating agreement. I have seen agreement as the outcome of rational debate, and not as a CONsensus that obscures differences and silences the voices of 'others'. However, in reaching agreement, the rules of the procedure itself as well as the content of that agreement, could be included in the negotiations. In the case of group inquiry this meant that each group could consider and reflect on the PROCESS at the same time as constructing accounts of becoming a midwife.

At the beginning of this thesis I outlined how this inquiry was part of a national evaluation of pre-registration midwifery education in England. At this important historical moment there was widespread public debate about the merits of the pre-registration route for midwifery education (see chapter one). The evaluation sought the views of those involved in midwifery education in order to inform that debate. In this thesis I have focused attention on two groups of students at two sites. Each group began a three year diploma course and agreed to take part in this research over a period of eighteen months. Through group inquiry I sought to give voice to their views, to enable them to examine their experiences of these new courses

and contribute to that public debate. Through dialogue and discussion each group constructed accounts of becoming a midwife and those accounts were presented in chapters three and four.

In chapter five I discussed in more detail key features of those accounts. Using the three themes of *participation*, *ways of knowing* and *emancipation*, I explored how, what it means to become a midwife, to be with women, could be understood in these terms. Autonomy was a central concern for many midwives, as indicated in the midwifery literature (see chapter one) and an idea which the students drew on in discussing their experiences of participating in higher education and midwifery practice. They, like other midwives, consistently emphasised differences between midwives and doctors, and midwives and nurses. As a political strategy I saw this as a form of identity politics, for the category of midwife was seen as fixed and unitary. Moreover the legal framework of midwifery practice and education, and the midwife's statutory responsibilities appeared to legitimise this view.

In asserting the professional identity of the midwife, the students appeared to value experience and practical knowledge and place considerable emphasis on the emotional work of caring for women. This *caring for* others, was what set them apart from doctors and placed them in a subordinate role. While doctors might subscribe to an ethic of care, they were not seen as caring for parturient women in the way that midwives did. Instead the ascendancy of scientific rationality and dominance of a medical model of childbirth was thought by the students, to severely limit what they could do. Midwives were expected by them to act as 'guardians of the normal' by seeking to promote a view of childbirth that was natural and normal. Although they had considerable difficulty in defining what was normal or challenging accepted practices, they aspired to a view of midwifery that valued both women and midwives.

Frequently the students expressed solidarity with women, believing that what was good for women could also be good for them. Yet there was a conflict with professional interests and on occasion they sought to distance themselves from qualified midwives who appeared to act in their own interests rather than "putting the woman first". By situating themselves between the women and the qualified midwives, the students sometimes tried to mediate the relationships between them. In the educational context

they also located themselves in a contradictory position. For while they clearly differentiated themselves from nurses, Group 1 did recognise that as students they shared similiar concerns to nursing colleagues. I argued therefore that by seeing identity as a discursive accomplishment, rather than as fixed, it was possible to suggest that midwives and nurses could work together for change. Pre-registration midwifery education was regarded as both an opportunity to enhance and strengthen the professional identity of midwives but could also provide an opportunity for dialogue between midwives and nurses. In the context of higher education, such an alliance could be both politically expedient and practically necessary if the voices of midwives were to be heard.

This discussion of knowledge and power in midwifery education highlights the issues of identity, representation and politics that were introduced in chapter two and elaborated here in chapter six. For earlier, when I outlined the ascendancy of scientific rationality in modern society and subsequent criticisms by sociologists of science, feminists and postmodernists, I showed how certain liberal assumptions underpinned notions of democracy and truth. In particular the liberal conception of a universal, rational subject, autonomous and able to participate freely in the production of knowledge, obscured the power relations that are a feature of modern society. Knowledge and power are unevenly distributed and irreducible differences remain between people. Yet we can not simply read knowledge off from the positions people occupy (standpoint theory), neither can we read knowledge off from membership of particular groups. Instead, as I have made explicit in this chapter, we need to see knowledge and power as mediated by language. A discourse model of legitimacy, emphasises that identities are co-constructed, that experience is discursively constructed, and that, through dialogue and co-operation, agreement may be reached about how we might live together.

By being 'with women' in group inquiry I came to understand what becoming a midwife might mean and by talking about becoming a midwife I gained a better understanding of group inquiry. The issues raised in relation to both the CONTENT and PROCESS relate to the organisation of knowledge and research in our society. For scientists continue to be able to make claims to be impartial, objective and value free, and often, as 'experts' they are unaccountable to others. This inquiry into knowledge and power in midwifery education illustrates that more recently doctors have been called

to account, and traditional assumptions about science in midwifery have become increasingly contested. In *Changing Childbirth* (DoH 1993 - see appendix 1) it seems that the voices of women and midwives have been heard, that service provision is expected to become more 'women-centred' and the knowledge and skills of midwives better used. However, this does not necessarily imply they are more highly valued, on the contrary it reflects the cheaper costs of midwives. Similarly the development of pre-registration midwifery education itself does not necessarily indicate a commitment by Government to a midwifery model of care, but must be understood in the context of changes in the financing and provision of education and training for health professionals (see chapter one and Kent et al 1994).

In this reflexive project, by adopting a participatory approach to research and questioning the production of "alienated knowledge" like other participatory researchers, I have sought to put participants at the centre of the research process. But I have also questioned the liberal assumptions of this approach to research. By integrating feminist theory with a model of democracy and a discourse theory of knowledge, I have shown how reflexive sociology may become a theoretical and practical possibility. Through group inquiry the voices of the students could be heard. In addition, in writing this thesis, I have found my own voice.

APPENDIX 1

CHANGING CHILDBIRTH - Summary and extracts

Following recommendations in The Health Committee Second Report on the Maternity Services in 1992 an expert maternity group was set up to review the maternity servcies. This group completed its report and produced the policy document *Changing Childbirth* in August 1993, after the group inquiry workshops were completed. These extracts from the executive summary of that report sets out proposed changes for maternity care nationally over the next five years. It will be in this changing environment that pre-registration student midwives will be working. The implications for their education and training have yet to worked out.

The fundamental principle which underpins all the proposals outlined in *Changing Childbirth* is that the woman and her baby should be at the centre of all planning and provision of maternity care. Women should be active partners in decisions controlling and shaping their care, and the role of the professionals working in the maternity services should be to support her in this.....

Women centred care

Maternity care must recognise that every woman has unique needs, deriving from her medical history, her particular ethnic, cultural social and family background and, importantly from her own wishes. the woman should be fully involved in planning her maternity care. She should take an active part in decisions about the sort of antenatal care she will receive, how and where she will give birth, and the professionals who will be involved in her care. A woman cannot make choices about these things unless informations a bout local maternity servcies is readily available to her. Throughout her pregnancy, the birth of her baby and afterwards, she must feel supported by the professionals who care for her and her baby.

Changing Childbirth identifies the three principles which should be the foundation for a woman centred service, together with points of action to help achieve this.

1.Appropriate care

The first key principle is that:

> *The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.*

Evidence received by the Group suggested that a service which is kind and reassuring can have a positive effect on the physical outcome of pregnancy. Women have made it clear that some of this reassurance comes from knowing their care-givers. The Group acknowledged the efforts already being made to improve the continuity of carer experienced by women. The report goes on to suggest ways in which that continuity might be improved more generally. One of these is

that every woman should have a lead professional with the key role in planning and provision of care.

Changing Childbirth considered the roles of the three main professional groups involved in maternity care: the general practitioner, the midwife and the obstetrician. Above all, it is vital that all professionals who provide maternity care should work together in the best interests of women and their babies.

The Expert Group recommends a review of the system of payment for general practitioners providing maternity care, together with criteria for inclusion on the obstetric list. The Group noted the unique continuity provided by family doctors who care for women before, during and after their pregnancy. The report recommends that midwives' skills should be fully utilised, and that they should play a full part in caring for women with uncomplicated pregnancies. A woman should be able to book with a midwife for the entire episode of her maternity care. The Expert Group recognises that there is a limit on the number of consultant obstetricians. As such, their skill and expertise is more appropriately directed first towards women with complicated pregnancies - but women with uncomplicated pregnancies should also be able to consult a obstetrician if they so wish. The duties undertaken by the obstetric senior house officer should more accurately reflect their trainee role, and their training should take place in the community as well as in the hospital.

2. Accessible Care

The second key principle is:

Maternity services must be readily ;and easily accessible to all women. They should be sensitive to the needs of the local population and based primarily in the community.

3. Effective and efficient services

The third key principle is:

> *Women should be involved in the monitoring and planning of maternity services to ensure that they are responsive to the needs of a changing society. In addtion the service should be effective and resources used efficiently.*

Tradition plays a large part in the way maternity care is provided. Practice is not always based on measures known to be effective, and, even where research has been widely publicised, ineffective and unproven practices continue. Equally, changes have been introduced which are not backed up with proper research-based evidence to support them. The Expert Group urges those who provide care (providers) to ensure that they implement practices of proven benefit and abandon those which have been demonstrated as ineffective. When the effect or benefit of a practice is unclear, it should be systematically evaluated. Existing patterns of

practice and organisation of services should not be exempt from evaluation.

The Group recognised that effective services tend to be efficient services. Purchasers must look for ways to maximise efficiency in the use of the resources available to them for the benefit of women. Duplication of professional effort benefits no-one, least of all women, and has obvious financial implications. Efficient services are those which make appropriate use of the skills of the various professional groups. A critical review of patterns of antenatal care could also lead to those services being more cost-effective, and free up resources for the further development of continuity of carer.

Changing Childbirth
OBJECTIVES

* Women should be fully involved whne decisions are to be made about their care.They should have a choice regarding the professional who will lead therir care and should, if they wish, carry otheir own case notes. They should be kept fully informed on matters relating to their care.

* Every woman should have the name of a midwife who works locally, is known to her, and whom she can contact for advice. She should also know the name of the lead professional who is responsbile for planning and monitoring her care. Wirhin 5 years, 75% of women should be cared for in labour by a midwife whom they have come to know during pregnancy.

* A woman with an uncomplicated pregnancy should, if she wishes, be able to book with a midwife as the lead professional for the entire episode of care including delivery in a general hospital.

* Antenatal care should be provided so as to maximise the use of resources. It should also ensure that the woman and er partner feel suported and fully informed throughout the pregnancy, and are prepared for the birth and the care of their baby.

* Women should receive clear, unbiased advice and be able to choose where they would like their baby to be born. Their right to make that choice should be respected and every practical effort made to achieve the outcome that the woamn believes is best for her baby and herself.

* When emergency services are required by the woman or her baby at, or around, the time of birth, they should be of the highest standard that can be achieved in the circumstances.

* Women shouuld have the opportunity to discuss their plans for labour and birth. Their decisions should be recorded in their birth plans and incorporated into their case notes. Every reasonable effort should be made to accommodate the wishes of the woman and her partner, and

to inform them of the services that are available to them.

* A woman who gives birth in hospital should return home, as far as is practicable, when she feels ready. Once home, she should be supported by her midwife, knowing that the general practitioner is available if medical advice is necessary. The pattern of support should be appropriate to the woman's needs and planned in consultation with her.

* GPs who wish to provide maternity care should receive appropriate training and encouragement to do so. Midwives and GPs should work in partnership in the best interests of the woman.

* The part which the midwife plays in maternity care should make full use of all her skills and knowledge, and reflect the full role for which she has been trained.

* The knowledge and skills of the obstetrician should be used primarily to provide advice, support and expertise for those women who have complicated pregnancies.

* The role and training of senior house officers working in obstetrics should be designed primarily to equip them with the skills and knowledge that they will require in order either to provide a full range of mternity servies working as general practitioners, or to continue their education and training to become obstetricians.

* Services should be based on an understanding of local health, social and cultural needs.

* Users of maternity services should be actively involved in planning and reviewing services. The lay representation must reflect ethnic, cultural and social mix of the local populations. A Maternity Liaison Committee should be established within every distict health authority.

* Information about maternity services should be provided in a form appropriate and accessible to women.

* Regular monitoring of the uptake of services should take place in order to identify those women who are least likely to seek care and use the service to their full advantage.A strategy shoudl then be developed to ensure that servicses are accessible to those women.

* Women with disabilities should have full access to servics and have confidence that their needs are fully understood.

* All women should have the opportunity to be fully involved in their care.

* Staff should receive training to enable them to support all women with different needs so that they can use the service to maximum advantage.

* Within a period of 5 years providers should be able to demonstrate a significant shift towards a more community-oriented service.

* The views of women who use the service should be regularly monitored and services adjusted to reflect their needs

* Clinical practice should be based on sound evidence and be subject to regular clinical audit.

* New patterns of service should be designed to allow evaluation of both their effectiveness and teir acceptability to women using the service.

* The service provided must represent value for money and the cost and benefits of alternative arrangements assessed locally.

Extracts taken from *Changing Childbirth 1993 HMSO.*

APPENDIX 2

MIDWIFERY LEGISLATION

1902	Midwives Act	midwives are licensed to practice rules regulating practice established
1920	Midwives Act	provision made for midwives to be appointed to Central Midwives Board although numbers restricted to a minority of 5/14.
1936	Midwives Act	Local authorities required to provide a midwifery service
1951	Midwives Act	consolidated legislation of 1902, 1918, 1926, 1936, 1950
1973	NHS Act	removed responsibility for personal health services from local authorities to NHS.

1979 Nursing, Midwifery & Health Visitors Act

1980 European Community Directives

1992 Nursing, Midwifery & Health Visitors Act

APPENDIX 3

EUROPEAN COMMUNITY DIRECTIVE 80/155/EEC Article 4

Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

1. to provide sound family planning information and advice;

2. to diagnose pregnancies and monitor normal pregnancies; to carry out the examinations necessary for the monitoring of the development of normal pregnancies;

3. to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk;

4. to provide a programme of parenthood preparation and a complete prepraration for childbirth including advice on hygiene and nutrition;

5. to care for and assist the mother during labour and to monitor the condition of the foetus in utero by the appropriate clinical and technical means;

6. to conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery;

7. to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assits the latter where appropriate; to take the necessary emergency meansures in the doctor's absence, in partiuclar the manual removal of the placenta. possibly followed by manual examination of the uterus;

8. to examine and care for the new-born infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resusitation;

9. to care for and monitor the progress of the mother in the post-natal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant;

10. to carry out the treatment prescribed by a doctor;

11. to maintain all necessary records.

APPENDIX 4

POLICY DEVELOPMENTS IN MIDWIFERY EDUCATION

1903 Registration of midwives began.
3 month training for all entrants to midwifery

1916 6 month training for direct entrants
4 month training for nurse entrants (3 months for those who have completed a course in gynaecology or childrens nursing).

1926 12 month training for direct entrants
6 month training for nurse entrants

[In 1929 fewer than 10% of entrants to midwifery were direct entrants]

1938 2 yrs training for direct entrants
1 yr training for nurse entrants:
Training divided into Part I - 18mths for direct entrants, 6mths for nurses
Part II - 6mths for all candidates

[In 1940 1/1366 candidates for the final examination in midwifery was a direct entrant]

1949 Stocks Report - in view of current circumstances recommended the cessation of midwifery training for direct entrants. Not implemented.

1968 Single period midwifery training introduced and Part I & II gradually phased out.

1972 Briggs Report - recommended all future midwives should be nurses and proposed a new curriculum design for nurse and midwife education comprising an 18month common core foundation programme followed by 18months in a specialist area of which midwifery was one. One year supervised practice would be necessary for midwives to work in Europe. Expected that midwives would complete a three year nurse education programme followed by a 1year post-registration midwifery course. The core foundation programme at certificate level would not , on its own be sufficient to practice as a nurse therefore those progressing to midwifery would be required to take an additional course to practice as nurses. Led to establishment of five statutory bodies responsible for regulation and control of nurse, midwife and health visitor education under the 1979 Act

1981 3 year training for direct entrants
18 month training for nurse entrants
CMB changes implemented in line with European Directives.

1985 Royal College of Nursing Judge Report on Nurse Education - developed recommendations of Briggs

English National Board Consultative Document on Professional Education and Training favoured the development of direct entry midwifery courses.

1986 United Kingdom Central Council Project 2000 recommended implementation of three year curriculum design with common core foundation programme and midwifery one of five "branches" of the tree of nursing. Links with higher education proposed as the new course would be at diploma level.
18month training for nurse entrants to midwifery continued.

1986 Association of Radical Midwives produced "The Vision" policy statement which centred on direct entry training for midwives.

1986 English National Board promote interest in direct entry training.

1987 Royal College of Midwives - The Role and Education of The Future Midwife in the United Kingdom.advocated a three year midwifery curriculum.

1988 Radford, N & Thompson, A. Direct Entry A Preparation for Practice - funded by DHSS to examine what inhibited implementation of direct entry courses and how development could be encouraged since despite support in principle for these courses by the DHSS and ENB there was only one current course in the UK.

1989 Department of Health provided pump-priming monies for seven new pre-registration midwifery courses to be extended to a further seven the following year.

1991 An Evaluation of Pre-Registration Midwifery Education in England Research Project funded by the Department of Health. To report in 1993/94.

This chronology draws heavily on the work of Radford & Thompson (1988).

APPENDIX 5
ORGANISATIONS ACTIVELY INVOLVED IN THE POLITICS OF MIDWIFERY

1. Association of Radical Midwives

The Association was formed in 1976 by a small group of student midwives from different training schools, who were alarmed by the apparent trend towards "maternity nurse" status in their training. With growing support from other student midwives, qualified midwives in all fields of practice, and from the women themselves who are consumers of maternity services, that undesirable trend is at least being challenged. A.R.M. can feel justifiably proud to have been part of the movemnet towards a more caring attitude in midwifery, and to have been insturmental in helping alert our colleagues to the threatened loss of our professional independence.
The word 'Radical' is used in its literary meaning of relating to roots and origins, and best expresses the hopes of that early group, that midwifery could find its way back to a position where midwives' skills were used to the full, while still taking full advantage of the benefit of modern technological advances, where these are seen to be in the best interests of the woman and her child. In other words, the hope that the true meaning of midwife ('with woman') will once more be realised in practice.

OBJECTIVES

1. To re-establish the confidence of the midwife in her own skills.
2. To share ideals, skills and information.
3. To encourage midwives in their support of women's active participation in birth.
4. To re-affirm the need for midwives to provide continuity of carers.
5. To explore alternative patterns of care.
6. To encourage evaluation of developments of our field.

(Taken from cover of the quarterly A.R.M. magazine)

2. United Kingdom Central Council for Nursing, Midwifery and Health Visiting

The Council is the statutory regulatory body for the nursing, midwifery and health visiting professions throughout the United Kingdom. The principal duties of the Council are to establish and improve standards of training and professional conduct for nurses, midwives and health visitors. These duties include:

- maintenance of a register of qualified nurses, midwives and health visitors;
- determination of the entry requirements for programmes of study which prepare for admission to the register;

- determination of the kind, standard and content of educational preparation
- the removal of person from the Register following investigation for unprofessional conduct or fitness to practice.
- establish and improve standards of professional conduct and provide advice on such matters
- specific legislation regarding midwifery practice (supplemented by the Midwives Rules and A Midwives Code of Practice.

The Council was established in 1979 by the Nurses, Midwives & Health Visitors Act and its duties revised in the 1992 Amendments to that Act.

(see UKCC Register Newsletter Spring 1993)

UKCC, 23 Portland Place, London W1N 3AF

3. The English National Board for Nursing, Midwifery and Health Visiting

Also established under the 1979 Act with responsibilities for the approval and regulation of training and education in England. Role and function reviewed in the Peat Marwick McLintock Report of 1989 (see chapter one) and subsequently organisation and responsibilities revised under the terms of the 1992 Nurses, Midwives & Health Visitors Act. Central Offices at Victory House, 170 Tottenham Court Road, London W1P OHA.

4. The Royal College of Midwives

Professional assocation for midwives, which provides advice and support on professional matters relating to midwifery. Also provides education and training, and contributes to policy debate at a national level. Membership by subscription, elected and appointed officers. Further information obtainable from RCM Headquarters, 15 Mansfield Street,London W1M OBE.

APPENDIX 6

Changes in funding arrangements for midwifery education

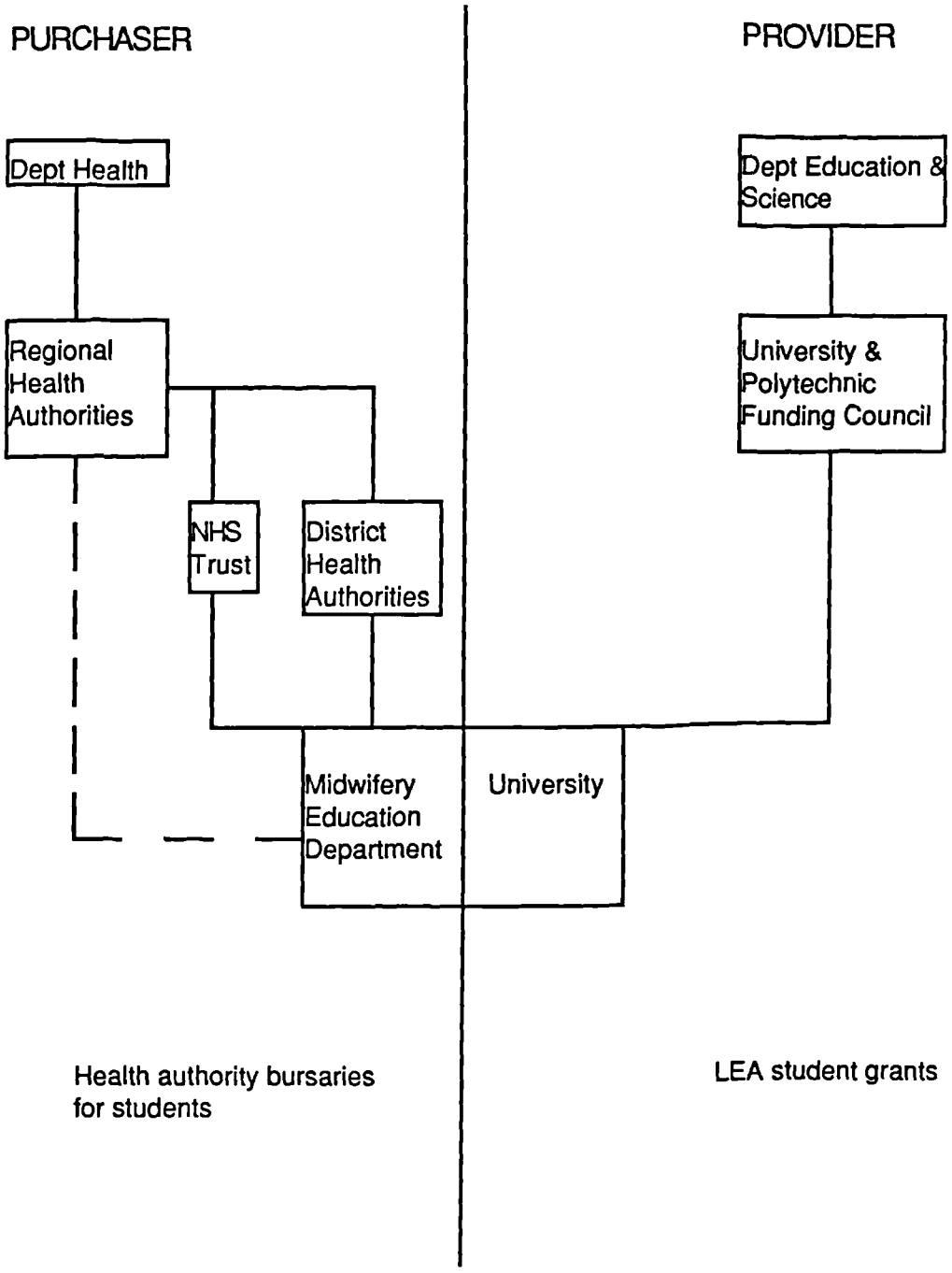
Extract from *Direct but Different : An evaluation of the implementation of pre-registration midwifery education in England (Kent et al 1994)*

The development of the internal market in health service education has been on-going over the period of this project and purchaser/provider relationships are the subject of continuing negotiation. Figure 1 illustrates the situation since April 1993. To some extent the financial arrangements for pre-registration midwifery education were (and still are) changing in all cases. While some re-organisation within midwifery education had taken place, further changes were anticipated with new links and amalgamations expected. Concurrent changes in health service finance had also had some influence. In the six case studies the educational institutions were described as 'serving' or having contractual arrangements with a number of health authorities and NHS trusts. These were in a state of flux as newly formed NHS trusts took over arrangements that had previously been set up. As a consequence the picture was confused, the future uncertain and only in limited ways did it become clearer as time moved on. As the education institution may have a range of contracts with different purchasers the number of contractors involved in each pre-registration midwifery course varied greatly. The relatively simple cases where only one purchaser was involved contrasts with the complexity of the arrangements at others where there were six purchasers for the course. In some cases the College provided other midwifery courses (eg. post-registration 78 week course) in different health authorities and trusts. The details of these contracts were not requested and in any case appeared difficult to determine.

There are many implications of these structural changes but the most pressing concerns for those involved in pre-registration midwifery were threefold. First, the future demand for pre-registration midwifery places would be controlled by purchasers and following Working Paper 10 (Department of Health 1989) the regional health authority's responsibility for education and training will be of key importance. This will be discussed further in chapter four. Second, the relationship between service and education was being restructured and this is discussed in the next section. Thirdly there had been a split in many cases between the financial and managerial responsibility for midwifery education. Where previously the senior midwife teacher or director of midwifery education had both financial and managerial control in many cases under the new arrangements they have no budget. Training contracts of the sort envisaged by Working paper 10 had not yet been worked out and both financial responsibility and accountability was unclear. On the one hand midwife teachers no longer had any control over their own capital assets as they became integrated into higher education while on the other hand there was no longer a service budget for providing midwifery education as service units became purchasers under the new terms. In some cases monies had been transferred from post-registration courses to the new pre-registration and where pump priming monies had been awarded, staff for developing the new course had been purchased. In the longer term it was uncertain what sources of funding would be available and direction from regions was awaited. Direct funding from region had not so far been implemented in any of the case studies.

Figure 1

A Diagram to show funding arrangements for pre-registration midwifery courses from April 1993



APPENDIX 7

Criteria for selecting six case study sites - extract taken from Kent (1992):

4.0 SELECTION OF SITES

At the time of selection in July 1991, fourteen sites[1] had either already begun pre-registration midwifery courses or had gained approval to commence in September 1991. Following preliminary visits to all sites, it was decided for both pragmatic and theoretical reasons to select six of these as case study sites. (One other site was used to pilot the research instruments).. The practical advantages of working more closely with a few of these sites quickly became obvious and consideration of the extent and type of in-depth fieldwork which would enable us to gain insight and understanding into pre-registration midwifery education, suggested that six sites would be manageable. In a sense this number was arbitrary but based on previous research experience and assessment of the resources available to the project. All other sites were invited to take part in a national survey described in section 7.0 below.

The criteria for selection are primarily concerned with the institutional arrangements for delivering pre-registration midwifery education. It is suggested that different organisational forms and curricula, will affect the experiences of those involved in the educational process. As underlying theoretical principles these will require further examination as the research progresses, they form the basis of a structural analysis of pre-registration midwifery education for they concern the context of the educational process.

There are directives and guidelines for the training and education of midwives set out by the European Community Council, United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the English National Board for Nursing, Midwifery and Health Visiting, and the product is intended to be the same for all programmes - a qualified midwife who is a safe, competent practitioner. The purpose of the research is to examine the different interpretations and views of pre-registration midwifery education in the light of those directives and guidelines.

First it was essential to gain the agreement of those sites visited to take part in the research, and this was one of the primary purposes of the preliminary visits. Our intention was to select six sites with a range of characteristics in order that we might explore in more detail their importance. A deliberate attempt was made to look for difference between the selected sites. The following criteria were used for making the selection (see appendix one for a list of sites visited and a summary profile of each).

4.1 Structure and organisation:

An awareness and understanding of organisational issues led us to consider this in various ways. We have identified that pre-registration courses are located either in a combined College of Nursing & Midwifery, a College of Health Studies, a department within a faculty of an institution of higher education or a separate College of Midwifery/Midwifery Education Department. Of the six sites selected, one is a Midwifery Education department, two are Colleges of Nursing & Midwifery, two are Colleges of Health Studies and one is in a department of an institution of higher education.

A further consideration has been the number of district health authorities served by the site. This varies from between one in two of the sites, and six at another site whilst the two other sites serve three health authorities and another is associated with four health authorities and two hospital trusts. This in turn may be

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[1] Selection was made from fourteen sites although subsequently two more sites gained approval to commence pre-registration midwifery courses in 1991.

related to the number of hospital sites used for student practice placements during the course.

4.2 Shared teaching and learning:
A range of different views have been expressed both in the literature and by those we have met, with regard to shared teaching and learning between pre-registration midwifery students and other students. The variation between pre-registration courses in different areas was noted and this considered an important criteria for selection on the basis that the amount and type of shared learning may influence the educational experiences of students and is an important part of the curriculum design. Of the sites selected, two have shared learning with nursing degree students while a third shares with medical and dental students. On two courses pre-registration midwifery students share with P2000 nurses, two other courses have no shared learning.

4.3 Research Convenience:
Accessibility to the selected sites was considered important in order to make the best use of researchers' time. Time spent travelling and away from base was a factor in decision making not only to ensure cost effectiveness, but to ensure that fieldwork is practically manageable. Consequently good railway links and distance from base was instrumental in the selection.

4.4 Geography:
Although initially it may have been expected that pre-registration midwifery courses would be evenly spread across the country, this is not the situation (see appendix two, Fig.1). While our intention was to achieve a geographical spread in our selection, on closer examination it was agreed that this should not become overly constraining, that other criteria were more important. Even so it has been possible to avoid selecting sites close to each other, the six sites are in different Regional Health Authorities (see appendix two, Fig.3).

4.5 Institutions of Higher Education:
Since midwifery education establishments may be linked with either a university, a polytechnic or a college of higher education for conjoint validation of the pre-registration midwifery course, a variety of these was sought. At four sites there are links with a polytechnic, one is linked to a university and the other to a college of higher education. It is likely that the nature of these links will vary but in each case, play a part in structuring the planning, validation and delivery of the new courses. The experiences of teachers and students will also be influenced by these links.

4.6 Qualification gained:
Pre-registration midwifery courses may be at degree level or a diploma of higher education. It is thought likely that the level of the course will affect the course structure and the experiences of students and teaching staff, therefore a mix of diploma and degree courses was sought. Of the six sites selected, three sites offer a degree course (one is a BA, two are BSc). four sites have a diploma course (one site has both).

4.7 Start date of the programme:
The development of pre-registration courses has been in two phases. Seven sites were approved and given pump priming monies in 1989/90 (phase one) and another seven received monies in 1990/91 (phase two). Other courses have been set up and are being planned without these monies and because of delays to starting dates they have in some cases begun before the fourteen pump primed sites. At the time of selection ten institutions were already running courses and four others were due to commence in autumn 1991. One of these was to be used as a pilot site.

It was decided that in order to gain a broader picture of the developing courses a combination of those which had already begun and those about to start would be preferable. According to when the course commenced it might be at a different

stage of development. The sites selected therefore include the earliest ones and two new courses which began in September 1991. There was a difficulty with including those courses with only an April intake, and one site which will not have a second intake of students until autumn 1992, since this could not easily be accommodated by the research timetable. Of those selected four are phase one sites, and the remainder have had no pump priming from the Department of Health. The resources available for the new courses will be of interest in the evaluation.

4.8 Number of students:

It was thought that the number of student places available on the courses may be a useful indicator of the size of the programme and a criteria for selection. However many of the courses are of similar size with intakes of between ten and fifteen students. One site will be increasing their yearly intake to a maximum of thirty students and another site has planned intakes of twenty two students twice a year. We selected the latter which is the largest College of Nursing and Midwifery in the country. The course with irregular intake dates which will have the smallest student numbers was not included for the reasons stated above.

It is possible that the number of students in each intake will structure their experiences as a group however other factors including the organisation and curriculum design of the course, type and quantity of shared learning are likely to affect the importance of student numbers.

4.9 Other criteria:

Other criteria were considered but were not instrumental in the decision making. These related to the provision of midwifery services in the localities of sites offering pre-registration midwifery education. It is recognised that the relationship between education and service is an important one in midwifery education. The form and distribution of midwifery services will have implications for midwifery education and changes in education have implications for midwifery services. Since students gain practice experience on placement in service areas (hospital and community) their educational experiences will be shaped by those services provided. The practice placements will be explored during the in-depth fieldwork but the distribution and provision of midwifery services is considered beyond the remit of this evaluation. It is only of interest in so far as it has implications for pre-registration midwifery education therefore specific features of service provision were not included as selection criteria.

APPENDIX 8

Follow up letter

To : All Group Inquiry Participants

29 October 1994

Dear
You may remember that during the inquiry group discussions last year we talked about the possibility of meeting up again when you finished your course. I have since thought it might be better if I contacted everyone individually to let you know about the progress I have made with the research and to find out how things have gone for you.

I have been working on my PhD thesis which is now in draft form and I hope to complete it early next year. I have recently produced two papers which relate to the inquiry workshops and I enclose copies of these for your interest. If you would like to comment on them at all I would be delighted to know what you think. The longer article *"Accounting for change in midwifery education: Identity politics or unity in diversity"* is a slightly revised version of a chapter from my thesis which sums up what were, for me, some of the key issues in understanding the development of pre-registration midwifery programmes. (this has not yet been submitted for publication so please do not quote from it until then.). In addition to continuing to work on the thesis I have been teaching research methods to students at the University of West of England where I work part-time as a lecturer in sociology. This has helped me to continue thinking about the group inquiry approach to research.

I feel that the last workshop was one 'ending' to the inquiry but because this took place when you were still half-way through your course it seems that we might see the completion of your training as another 'ending'. I am therefore very interested to know:

a) What are your views now about the course you have completed?
b) and what, in retrospect, is your view of the inquiry?

If you have the time and are willing to write to me giving a brief summary of your current views on these two aspects of the research I would be most grateful. If you prefer you could telephone me at home on BATH (0225) 858116 and I will be pleased to phone you back. Finally,
c) what recommendations would you make for the future development of pre-registration midwifery education?.
With your permission, I would like to include your replies at the end of my thesis. They will anonymous so that no-one may be identified.

I wish you well in the future and thank you again for all your help, for without you, this research would not have been possible.
Best wishes,

Julie Kent.

APPENDIX 9 GROUP INQUIRY 1

An agreed account of the students' experience of inquiring together.(Process). (reproduced in Kent et al 1994)

Workshop 1
A few weeks after beginning the course we received a letter from JK inviting us to take part in a research project. We met her to find out more and then while she left the room we all decided whether or not to take part. We were a large student group (16) and all those present agreed to be involved (14/16) though perhaps some of us were less keen than others. Some felt it was a positive opportunity and hoped that the research would aid the development of pre-registration midwifery courses.

At this time we didn't know each other and we were unsure of our individual positions within the group and in the college. We were also unsure of what it might mean to be involved in research and were a little wary of what we might be getting into. JK asked to tape record the meetings so that we had a record of what took place. Some of us felt a bit nervous of being taped and didn't want to sit close to the recorder - it was all rather daunting.

We then brainstormed why had we become student midwives? This worked well and threw up lots of ideas. It was a good way of breaking the ice as it didn't put pressure on individuals to make comments or feel embarassed about their reasons for coming on the course. It was a useful way of obtaining information from such a large group and getting the discussion going.

We then talked in small groups about what being a midwife meant to us, writing down notes on flipchart paper. We also talked in pairs about good and bad experiences we had so far, what we were looking forward to on the course and what we were not looking forward to. We then discussed these in the large group (when talking in small groups the tape recorder was turned off). This was the group's first opportunity to discuss our fears, hopes and expectations and it helped to know that the discussion was in confidence and we could speak freely.

We realised that we had many of the same feelings and anxieties and it was interesting to compare ourselves with each other. Many of the topics had relevance to our position on the course and it was good to be able to discuss things between us and not be told what to do - we could make the decisions. The group did however seem rather large for this type of inquiry.

Workshop 2
We recongised that participation in the research was voluntary but having a timetabled slot enabled us to attend the workshop which we would otherwise not have had time for. We received a letter from JK (see appendix) about the next meeting together with a copy of feedback from Workshop 1. We were asked to look at the feedback and try to identify

themes from our statements about why we had come on the course and what being a midwife meant to us. This was a way of sharing in the work of analysis and being "co-researchers". It was quite difficult and we discussed this in this second workshop.

We were also asked to write about a significant event- something which had occurred since the course started which seemed significant for understanding the process of becoming a midwife. We were asked to write in the third person, as though the event happened to someone else so that we distanced ourselves from it and tried to reflect on and critically analyse the process of becoming a midwife. We were to include details of where it had happened, what took place and what we had learnt. We also were asked to indicate whether it was a positive or negative experience. Some of us found this more difficult than others. The guidelines were seen as helpful but others were uncertain what was being asked and thought they were expected to write an essay. Only a few prepared their account before the workshop and two more were sent in later (a total of four written accounts completed). Writing about significant events gave us a chance to share experiences, and it was helpful for those of us who were having difficulties mastering skills to see that others also had difficulty and that with practice and perserverance we would progress. There were group members who felt slightly embarrassed at what they had written but it was early days and we were learning a lot. Writing was seen as a way of expressing more exactly what we meant though a later suggestion was that it might have been easier to keep a diary for a day.

This workshop took place on a bad day. We had all been stressed about presenting work to each other in the morning class and some students were upset by what had happened. There were also divisions emerging within the group. Nevertheless we laughed a lot during the workshop and enjoyed it. At the end we were given an evaluation sheet to complete so that we could disagree or agree with the group view. These were considered a good way of finding out how much was common to all. Of those sent to JK (7/16) there was a lot of agreement indicated. It was noted however that the more confident ones in the group say more and it was important that everyone got a chance to speak so more work in pairs or small groups was seen as preferable and a chance to write things down individually beneficial. At times it did seem hard to find links between what people said in such a mixed group.

All the group were also invited to complete a postal questionnaire for the national survey but while these were seen as providing individuals a chance to speak in confidence they were also thought to require extra commitment for completion and return. (10/16 replied).

Six students did not attend this workshop and some were unsure about whether to continue taking part, another student had left the course. They were sent a letter outlining what had been discussed and an evaluation sheet. They were also invited to send in any account they may have written. In a smaller group many of the students who had not previously spoken in the large group now began to find their voices. The inquiry was seen as allowing individuals to

express their feelings and thoughts because all comments were taken to be relevant and JK was there to hear them. There were no right or wrong answers.

Workshop 3

There were tensions within our student group that spilled over into the inquiry. By this time another student had left the course and eight were present for the workshop. However when one said she would not speak while the tape recorder was on, or write anything but would listen to what others had to say we felt this was inappropriate. It was agreed that she could not take part under these conditions and she too left the inquiry group.

Seven of us remained and everyone agreed it was much easier to talk in a smaller group. It was unclear whether the others wanted to continue so it was decided that JK would write to each of them asking them if they still wished to take part. We all felt more comfortable and found the session enjoyable. It was easier to express opinions and a group of this size was less intrusive, more intimate and participating more beneficial. It was a good way of getting information about the course and what it was like being a student midwife. As the sessions were confidential it was easier to discuss our concerns and identifying the goals and problems we had was very helpful. It helped to confirm that we were being reasonable and to assist us in tackling the difficulties together as a group. Pair work was less effective and more often we talked together as one group.

We talked about our experiences of being in groups, the benefits and disadvantages. How it can provide a support network and be enjoyable as well as enable people to share experiences. We recognised that we needed to respect each other's opinions, listen to each other, treat them as we would wish to be treated and know when to speak, when to keep quiet. A small group was seen as more relaxed but groups were also thought to sometimes prevent independence and create a feeling of being judged.

The inquiry was a useful tool for reflective practice. We reflected on what had happened to us over the past three months and tried to identify what the issues were for us in these accounts and the earlier ones we had written. The session raised some very appropriate questions and enabled us to reflect on recent events, and clarify the effects of recent placements. We decided we didn't have the time to write accounts of our experiences so instead we would focus on one theme to discuss at our next workshop. JK gave us a copy of a paper written by her on group inquiry method (Kent 1992).

Workshop 4

There were now eight students in the inquiry group- four students had left the course and four had withdrawn from the research. As usual we received feedback from the previous workshop and had the chance to comment on it. We seldom did, though reading it through was interesting. The theme we had identified for discussion at this fourth workshop was

"fitting in" - how we were coping with fitting into the hospital system.

We recounted our recent experiences and considered whether the issues were the same as they had been three months ago. This was good looking back to see whether anything had changed and it was heartening to see the problems we had overcome. We looked at the similarities and differences in our experience and were able to say what we wanted to not what other people wanted us to say. Next we tried to identify features of the hospital and those things which had most significance for us as students. In trying to make sense of these experiences we looked at the work of Melia (1984) and considered how useful the concepts of socialisation and social control might be in explaining how we become midwives, the ways in which we learnt how to behave and what to do.

We then drew diagrams of midwifery service and midwifery education and examined the influence these structures might have on us as students.

Finally we discussed whether taking part in a national evaluation could make a difference or change anything for us. We wanted to be listened to and thought perhaps this was a way of achieving that but we weren't sure. We also wanted to make contact with students from other pre-registration midwifery courses but JK wasn't able to do that for us. She did offer to send us a list of courses so that we could make contact if we wished.

We enjoyed taking part in the inquiry and no longer felt inhibited by being in a group. This led to a better discussion and more material was generated. It was easier for people to express themselves in a small confidential group. It was beneficial to be able to express ourselves.

Workshop 5

The topic we had chosen for this session was 'Change in midwifery education'. We talked a lot and collectively told our story - our experiences of the changes that were taking place locally. We shared feelings of anger, frustration and stress. We were all very depressed and low in self esteem and used this as a "moan" session . Talking in the group was an opportunity to air these problems and was very beneficial. It gave us a chance to reflect on these changes in an informal situation and to be listened to. It was good to feel that JK was listening to us and this helped us to realise how little we knew of the changes in education and to explore the effect of the "upheavals" on every member of the group. In one sense talking through these troubles was "therapeutic". It also seemed that JK helped us sort out rationally what the problems were by asking us prompting questions. We had a lot of complaints and were confused about how to deal with them and the session helped us in thinking about what to do. We all had a chance to express our opinions. But we felt let down, especially by midwife teachers who clearly had their own problems. So the group supported each other which brought us closer together.

We discussed the article by Warwick (1992) and considered how far midwives have lost control of their education. We

related well to this paper though we felt it was already rather out of date. We also considered briefly theories of power - how power is exercised through agenda setting, decision making and at the level of ideas and JK asked are midwives involved in setting the agenda or making decisions? Where do our ideas come from?

We were very negative in this session and decided to try to look more positively next time at our practice placements.

Workshop 6

We had read the feedback from workshop 5 which some of us found very interesting and enjoyable to read. It was suggested that it provided a rather "tame" version of events that we had discussed.

Since we saw ourselves as "clinically based students with a theoretical input" we wanted to consider in more detail our clinical base and experience of the practical placements. As we were based at three different hospitals we began this session by describing the delivery of midwifery care at each, for our experiences could be better understood against this background.

We each drew a diagram or map of where we had got to on the course (see appendix). While most of us enjoyed doing this some did not, and found it difficult to put things on paper especially because they see themselves as having little artistic ability. Some of the "picturegrams" were very tidy and concise, others very unihibited and not all were understood by the group but this was not percieved as a problem. We laughed a lot doing this and teased each other about what we had drawn.

JK asked us to write down what was enjoyable and less enjoyable about the placements we had so far and then we discussed aspects of the role of the midwife - how it could be defined and whether the role of the midwife will be affected by the development of pre-registration midwifery education. We listed some of the skills of the midwife and thought about what was helpful in learning these skills and what obstacles we had come across. After listening to the article by Kargar (1990) read by JK we asked whether we are learning traditional midwifery skills. JK also asked how competing definitions of the role of the midwife and how midwifery care should be delivered had affected our experience as student midwives. Some of us felt that there was a narrow view within the group and a reluctance to look at other perspectives.

Finally we identified those things we would like to change about the practice placements and then discussed how to write about the inquiry. It was suggested by one of us that it would have been good if we could continue the inquiry to look at the nursing placements which were next in our programme.

Workshop 7

We met JK at the university for the first time. Seven of us attended this final workshop (one of the group was ill) and six of us had managed to write some notes in preparation for

writing a report. We had lots of comments to make about what should go into the report and it was good looking back over what had been achieved. We discussed each of the six previous workshops and considered what important points had come up.

We discussed whether to present a paper with JK at a student conference or to identify ourselves as co-authors in the account we were producing. There were mixed views in the group and while some very keen to be identified, others were uncertain whether it might have a negative effect on us as students or even newly qualified midwives seeking employment next year. It was also noted that we had felt able to talk freely in the group precisely because it had been confidential and anonymous and some of us were not keen to give up that anonymity. Since we all needed to agree on this it was decided to wait and see what the report looked like when it was finished and then each decide whether or not to be identified. JK seemed happy with this and agreed to send the draft as soon as possible for our comments.

Taking part in group inquiry had been fun and provided us withg a useful opportunity to reflect on our practice and our achievements over the past eighteen months. The question remained, would others learn from our experiences and, after all, can we make a difference?

APPENDIX 10 GROUP INQUIRY 1

Workshop Plans 1-6

INTRODUCTORY WORKSHOP : Group Inquiry

BRAINSTORM Why did you become a learner midwife? (5mins)

GROUPWORK In small groups (four people) consider (15mins)

"Becoming a midwife- what does it mean?"

Record on flipchart paper.
Choose someone to present the groupwork to the others.
Feedback.
(10mins)

PAIRS In pairs tell your partner (10mins)

a) One good experience and one bad experience since you started this course.

b) One thing you are not looking forward to on the pre-registration course and one thing you are looking forward to in the course.

FEEDBACK on flipchart. (10mins)

TAKING PART IN RESEARCH- Discuss in fours your experiences of taking part in research if any, and why you want to take part in this research.

ANY QUESTIONS?

Important to look at the topic "the experiences of becoming midwife" and the research process - being in a group etc.

WORKSHOP TWO

Feedback - analysis on flipchart to share themes identified - each person to contribute two themes then go round the group again until all themes listed. (20mins)

Groupwork - discuss list generated to see if any of these may be grouped together (25-35mins).
Rank them in order of importance?

[At end of session, on the evaluation sheets I will ask individuals to say how important these things are to you.]

Small groups- in small groups read out accounts to each other and discuss, similarities or differences. Choose one of the accounts to read to the large group.(allow 3-4mins for each person) (15mins)

Groupwork - Read out accounts - ask each group to say why they chose it. Why were these significant events?

Look for similarities/differences between accounts.

(20mins)

Collect in all accounts of significant events.

Reflecting on group inquiry - spend some time considering the research process - what has the experience been like, is everyone getting a chance to say what they want to? How do group processes affect the research?

(15mins)

Agenda for next meeting - begin analysing the significant events. Perhaps take one theme to consider again in detail. **Arrange date and time.**

Evaluation forms- to take away and post to me using the freepost envelopes. How much to do you agree or disagree with the group consensus? Were there other themes/issues you would like to have discussed?

WORKSHOP THREE - plan

1. Go round the room asking **each person to say something about what has happened to them over the last three months.**

   Opposite person writes on flipchart so that each person has recorded someone else's account and given an account of their own.

   (20mins)

2. **Are the issues raised or these 'events' the same as those written about in the accounts?**
   - Hand out the accounts and ask volunteers to read an account aloud to the group.

3. List the issues on flip chart.

   (25mins)

4. **What would you like to do about these issues? What stops you from doing these things?-** discuss in small groups and feed back to large group

   (25mins)

5. List actions which group might take on flip chart.

   (10mins)

6. Being in groups - **talk to your neighbour about your experience of being in groups,** then your neighbour will report on what you said to the large group.

Record on flip chart. -what does this tell us about the research process group inquiry? Give out evaluation sheets. Invite people to take a copy of Working Paper 1 extract.

(20mins)

7. Agenda for next meeting?
   Should the group write more accounts?
   Discuss in more depth, an issue raised from the accounts and experiences recounted today?

(15mins)

WORKSHOP FOUR - PLAN

1. Go round the room asking for the latest news - tell the group about one good thing and one not so good thing that has happened recently on the course.

2. In pairs look at the feedback sheet No2 - are the issues the same now or have they changed if so how?

   Feedback

3. How might we describe a hospital - what are the features of hospitals? BRAINSTORM

   - hierarchy
   - bureaucracy
   - routines
   - clinical environment eg. smells, machines.
   - personnel wear uniforms
   - time discipline
   - lack of privacy

4. What is it about being in a hospital which is significant to you as student midwives? Each person say one thing. List on flip chart.

5. "Learning the rules": extract Melia (1987).Discuss

   What are the "unwritten rules" in becoming a midwife? In two groups list on flipchart.

   FEEDBACK

   (Introduce idea of social control through socialisation - learning values, behaviours of profession - What do you think of this idea? -does this explain anything, if not why not?)

6. In two groups

   GROUP A
   List the people who are involved in midwifery services

   eg. midwives, students, women and families, doctors, physiotherapists, ward sister, clinical manager, director of midwifery services,

Try to draw the hospital structure.

GROUP B
List all the people involved in the pre-registration midwifery course.

Try to draw the structure of the College.

FEEDBACK

What are the consequences of these structures?
(A way of organising care/education. A formal system of control.)

What problems does this illuminate? Could we spend some more time on these in the next workshop?
If it is of no importance, why not?

7. Plan next workshop

WORKSHOP 5 -Plan

The theme of this workshop is
"Change in midwifery education" and introduces concepts of **power** as an explanatory framework.

As a group can you now draw on flip chart the new organisational structure and identify its features?. (someone act as scribe)

Each person say something about how the changes have affected them.

So why are these changes significant? - discuss with neighbour and report back to the rest of the group.

List effects of change.

Which of these are specific to them as midwifery students?

Discuss article by Warwick (1992) -what did you think about it? Do you agree with her?

Power- theories of power suggest that power is exercised in different ways -

1. by agenda setting (deciding what will be discussed)

2. by decision-making (excluding people from the decision-making process)

3. at the level of ideas (where the process by which some ideas come to dominate is disguised and ideas as seen as "facts" -self-evidently true and unquestionable)

So .....
Are midwives involved in shaping the agenda or choosing what are important questions to be asked about midwifery education?

Are midwives taking part in the decision-making? Are they equal partners with the others involved?

Are ideas about what counts as a midwife being questioned a) by midwives themselves and b) by non-midwives?

What kind of ideas about midwives dominate? (what kind of language is used to talk about midwives?, and by midwives?)

How does this affect you as student midwives?

Are you directly involved in these struggles in any way? If yes, how? If no, why is that?

Programme for evaluation and group inquiry:

WORKSHOP 6 - Plan

Any comments on feedback from Workshop 5?

We ended that session by thinking about different views of midwives. It was suggested that the idea midwives attend university courses is based on a view of you primarily as students. You contrasted this with a view of yourselves as "clinically based students with a thoeretical input". So in this workshop we are going to focus more on that clinical base and the PRACTICE PLACEMENTS.

We have already looked at the organisation and management of the maternity service but could we now think more about THE DELIVERY OF CARE

Will someone from each hospital decribe briefly the pattern of care mothers recieve there. For it is against this background that we might understand better your placement experiences.

FEEDBACK

You have already talked about the placements in previous workshops, as an indicator of where you have got to now -

Each person draw a map of yourself on the course showing the placements and time spent there.

FEEDBACK

Individually write down those aspects of the placements which you have
a) enjoyed

b) less enjoyable

FEEDBACK on flipchart

Why were these enjoyable/unenjoyable?

How would you describe the role of the midwife?

In two's write down a description of how you see the role of the midwife.

FEEDBACK

So what skills do midwives need?

BRAINSTORM

What has been most helpful in the learning/developing the skills of the midwife?

What in have been the obstacles to learning/developing the skills of the midwife?

Discuss with neighbour FEEDBACK

Reading through the article by Ishbel Khargar - to what extent have you become aware of competing views of how midwifery care may be delivered and the role of the midwife?

How has this affected your experiences as midwifery students?

Each person say one thing they would like to change about the practice placements

FEEDBACK

Finally in thinking about how to write up the Group inquiry please take away this sheet and prepare for our next meeting on MAY 11th 1993 at 1000hrs

APPENDIX 11

Letter inviting students to participate in group inquiry

To Pre-Registration Student Midwives

24 September 1991

re: AN EVALUATION OF PRE-REGISTRATION MIDWIFERY EDUCATION AND TRAINING : A RESEARCH PROJECT FOR THE DEPARTMENT OF HEALTH

Thank you for agreeing to meet me on Friday 4th October at 2.00pm. Enclosed with this letter is a leaflet which introduces MRA and explains what we are doing. The purpose of our meeting will be to explain, in more detail, the research project and to invite you to take.

The study includes in-depth fieldwork in six case study sites where there are pre-registration midwifery courses. This College of Midwifery & Nursing has agreed to become a case study site.

The particular method used here, (and one other case study site), depends on the active, but voluntary, participation of students on the pre-registration midwifery course. I would like the opportunity to discuss this with you.

I look forward to meeting you.

Yours sincerely,

Julie Kent
Research Associate

APPENDIX 12

Guidelines for writing about "A Significant Event"

What is "a significant event"? You must decide but it will be something which had an effect on the way you think about yourself as a student midwife. Please bring to our next meeting an account of a significant event which has occurred since you began the pre-registration midwifery course. Here are a few guidelines for writing your account.

Aims:

- to **describe** an event which seems significant in understanding the process of becoming a midwife.
- to enable **critical analysis and reflection** on the process of becoming a midwife.
- to **learn** about what being a midwife means.

Don't worry too much about writing lots, what really matters is including:

1. the context or setting of the event
2. a description of what happened
3. the outcome of the event
4. why it was significant to you
5. how you felt about the experience, was it positive or negative?
6. what you learnt from this event

Write the account as though it happened to someone else - in the third person. Rather than writing "I saw that....." write "Jane saw that...." Please be prepared to share and discuss the accounts in the group.

[These accounts are sometimes called "critical incidents". Patricia Benner discusses them in her important book From Novice to Expert. Addison Wesley. London. 1984]

APPENDIX 13

EVALUATION SHEET 1

This is an individual evaluation sheet. Following the group discussion we identified the following themes. In your view how important are they to **you ? Please circle how you rate them in importance to you personally.**

.....

Not at all important Unimportant No strong feelings Important Very important

1 2 3 4 5

.....

Not at all important Unimportant No strong feelings Important Very important

1 2 3 4 5

.....

Not at all important Unimportant No strong feelings Important Very important

1 2 3 4 5

.....

Not at all important Unimportant No strong feelings Important Very important

1 2 3 4 5

One of the reasons for completing this evaluation sheet is to see how far individuals in the group agree with the explanations we have generated. Are there any other themes you feel were not discussed by the group? Please list them here:

Are there any other comments you would like to make about either the analysis or the group discussion?

PLEASE SEND THE EVALUATION SHEET TO ME USING THE FREEPOST ENVELOPE PROVIDED. AT THE NEXT MEETING WE WILL DISCUSS THE INFORMATION GAINED FROM THIS EVALUATION.
THANK YOU

JK/1/92

APPENDIX 14

WRITING A REPORT ON GROUP INQUIRY - notes of guidance

The purpose of group inquiry was to describe and explain your experiences of being on a pre-registration midwifery course. The group inquiry method aims to encourage participants to reflect on, and critically analyse, those experiences. This means that, in contrast to other research methods, group inquiry members take part in the work of analysis. In order to present our work to others, in the evaluation report we need to construct an account of group inquiry. The purpose of the next meeting is to discuss how we achieve this. In order to help our discussion,it would be most helpful if each person could come with an outline of what they think should go into the report. This is to help you draw up that outline. It will take time to do this but I hope you will agree that it is worthwhile!

In contributing to the writing of this report you are being asked to do three things:

1. Reflect on being a pre-registration midwifery student

2. Reflect on the group inquiry process

3. Assist in constructing a public account of group inquiry.

I suggest therefore that we divide the report into two sections.(If you have any queries do please telephone me on 0225 858116 as we will only have a short amount of time to prepare the report)

SECTION A - <u>The experience of being a student on a pre-registration midwifery course</u>

This section will be written as if a student is telling a story about being on the course and becoming a midwife. It will present the voice of a student. Because the story will be a collection of ideas from the group it will represent the views of the group rather than be about any particular individual person.

From the workshop notes try to pick out what you think are the important points that we discussed at each workshop, which should now be included in the story. Jot down the points in the space for each workshop, continuing on the back of the page if necessary. (The figures in brackets are the reference numbers for each record or feedback sheet).

WORKSHOP 1 (GI)(01)(03)

WORKSHOP 2 (GI)(01)(12), (GI)(01)(13)

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WORKSHOP  3  (GI)(01)(17)
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WORKSHOP  4  (GI)(01)(20c)
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WORKSHOP 5 (GI)(01)(25)

WORKSHOP 6 (GI)(01)(29) [I will post this to you before the next meeting]

SECTION B - The group inquiry process

We need to describe the group inquiry process since, in order to understand the story of the student on the course, readers will need to know how we produced this account. The method used to understand your experiences of being on the course is an important part of the analysis. All research gives a description of the methods used but a feature of group inquiry is that participants are encouraged to reflect on the method.

From the workshop notes and the additional information on group inquiry please identify the key features of the group inquiry method and comment on your experience of taking part.

Additional information on group inquiry method is in (GI)(01/03)(04), (GI)(01/03)(10) and (GI)(01/03)(16).

WORKSHOP 1 (GI)(01)(03)

WORKSHOP 2 (GI)(01)(12), (GI)(01)(13)

WORKSHOP 3 (GI)(01)(17)

WORKSHOP 4 (GI)(01)(20c)

WORKSHOP 5 (GI)(01)(25)

WORKSHOP 6 (GI)(01)( ) [I will post this to you before the next meeting]

THANK YOU FOR YOUR TIME.
PLEASE BRING THIS WITH YOU TO THE NEXT MEETING

JK/1/93

APPENDIX 15 GROUP INQUIRY 1

AN EXAMPLE OF THE FEEDBACK SHEETS SENT TO STUDENTS AFTER EACH WORKSHOP AND USED TO WRITE A GROUP INQUIRY REPORT:

Workshop 6 - Feedback

Workshop 6 was held on Friday 5th February at P. All nine group members were present[2]. Comments on the previous workshop were invited- One group member said how she had enjoyed reading about it, another said it seemed rather "tame" Following from that meeting we had decided to look more closely at the idea of the group as "clinically based students with a theoretical input". So the focus of this session was

"Experiences of the Practice Placements."

1.0 **The delivery of care**

While an earlier meeting had looked at the organisation and management of the service we wanted to think more about how **care** is delivered in the three hospitals where the group gain practical experience. We began by one person from each of the three sites outlining the pattern of care women recieve.

D NHS Trust

The wards are all separate and students are allocated to each ward for about six weeks at a time. Women have shared care with GP and midwife and will visit the antenatal clinic at intervals, depending on their history. The majority of women deliver in hospital. Some come in with their community midwife under the domino scheme when they are delivered and stay in hospital for six hours. Students are allocated to work in the separate wards with different midwives. Team midwifery may be introduced at some future date. One student thought that it was useful to spend a length of time in each area since it enabled her to gain experience and get the required number of deliveries done, another was less convinced that this counts as an advantage.

P NHS Trust

At "booking" a woman in the antenatal clinic is allocated to a team of midwives and will meet a midwife team member there. She may see that midwife again in antenatal clinic but the teams are large. There are four teams in the hospital. Each team works on a ward and each consultant has a ward. The wards are mixed antenatal and postnatal beds. There is little chance of following a woman through pregnancy, delivery and post-natal although it is more likely that a midwife who delivers the woman will see her post-natally when there is some continuity. It is thought that, in the future, the teams might be made smaller. Students are allocated to work on the wards, with a team.

B NHS Trust

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2 Eight midwifery students plus JK

During 1992 there have been significant changes in B. The old unit closed and a new midwifery -led unit opened (17 beds) catering for "low risk women" and "high risk women" through the antenatal clinic. There are no "high risk beds" in B. If "high risk women" need admitting antenatally, they go to P and all "high risk women" are delivered there. although these women can attend antenatal clinic in B. "High risk women" are seen regularly by the Registrar or Consultant while "low risk women" are booked by and seen by a midwife, unless there is a problem. The unit is very small and midwives work between the antenatal and postnatal wards In the morning at the beginning of a shift students can be allocated some women in the postnatal ward, if they delivered a woman they can ask to look after her there. Lately there have been more staff than women. There is "quite a lot of continuity" and if a student sees a woman come into labour ward who they have booked in the antenatal clinic the student may ask to care for her. Generally midwives work across all areas of the unit although some don't like to work in the antenatal clinic and won't go there. Booking clinics take place on a set day, midwives arrange for scans and other investigations. Midwives refer a woman at booking to the consultant or later, if there are any queries . Some women have asked to deliver in the unit but the consultant won't agree and sends them to P (due to the lack of facilities at B).

Students have asked to move between the sites to see how the other units work but this has not been possible so far. This is a continuing subject of negotiatiation. One of the group is transferring to Salisbury. It was thought that the staffing levels of the unit, particularly at B, influences whether students may be placed there. But another group member suggested that although the students are "supernumerary" (ie not counted in the staff numbers), they still liked to have a full complement of students on placement. At present there are very few students placed in the midwifery-led unit. Of the group, two are at B; three are at P and three are at D.

2.0 Where have you got to on the course?

JK asked the others in the group to draw a pathway or map of where they are on the course, showing the placements and indicating time. This was to enable each person to locate themselves on the course and illustrate the pattern of placements. Each diagram was very different . Time was represented as a clock, histogram, steps, distance along a path, road, railway (see diagrams attached). The pattern of placements was visible and I have identified the following features :

1. Each week is split between practice and study. The proportion of time for practice increases as the course progresses.

Sept91 - Feb92	March 92- Feb 93	March 93- Sept 94
2days practice, 3days study	3days practice 2days study	4days practice 1day study

2. Each student has had experience of community (including visits with the health visitor and social worker, and a visit to a special school), paediatrics(2days), antenatal clinic, antenatal wards, delivery suite, and postnatal wards. Those at D are able to identify and quantify the block of time spent in each area, whereas for those at P, and especially in B, time spent in these clinical areas is integrated in the midwifery placement as students move between areas.

3. During the next year the group will be working in the community, general wards (theatre, gynaecology, male surgical, psychiatry and special care baby unit). They will work nights and weekends on the midwifery units.

4. Those students working with teams have a chance to change teams.

These diagrams provoked a lot of comment and laughter!!!!!! This mainly related to the skills of colleagues in drawing and representing the placements.

3.0 Which aspects of the placement were enjoyable and which were less enjoyable? And why?

Placements were enjoyable if there was plenty to do, a variety of things to get involved in and good support from a mentor. When the tasks became repetitive students were bored, and if activities were not organised they felt time was being wasted and at a loss as to what to do. *"Having a good mentor to work with"* was seen as extremely important and made all the difference to the students enjoyment and learning. In D this was a continuing problem and one group member described how she had worked with ten different mentors in one placement and only three times with the same mentor. Recently workshops had been organised to prepare and train the mentors so that better support may be provided to the students.*"they have been told that those books are continuous assessment and there is no way that they should fill in anything in that book until they feel we are completely competent"*. Another student (at P) explained how she had one mentor who she could *"relate"* to well but often worked with other midwives and this is really good as long as there was one person you could get on with. Not having a mentor felt stressful but in a smaller unit, like B, the small numbers of staff meant that the students were able to get to know all staff fairly well. But in that context staff relationships were still very significant and *"personalities"* influenced the atmosphere of the working day and the student's experience. There was a feeling that in D where the organisation of care is fragmented between different clinical areas, working with a mentor had greater importance than in other units where students participated in a system of care that had more continuity.

The community experience was viewed positively by all students especially in the early part of the course. Antenatal clinics were least popular although some enjoyed taking booking histories the routine checks and clinic experience was not enjoyed. Paediatric placements were also unpopular and had been shortened following evaluation by earlier groups, although two in the group had enjoyed the experience

ENJOYABLE	LESS ENJOYABLE
Community *"enjoyable at the beginning"*	**Community** *"got repetitive and boring"*
Hospital	**Antenatal clinic**
Community *"good at beginning"*	**Community**
Paediatrics	
Hospital	**Antenatal clinic**
Community *"enjoyed it all through although it got monotonous"*	
Paediatrics (4days long) *"but did quite a lot"*	
	Antenatal clinic *"don't like doing the antenatal checks, nothing to do in clinics except getting notes, filing"*
Hospital (inc booking clinic like taking histories)	
Going out with the Health Visitor	
Community	**Special school(1day)**
Antenatal clinic *"I like doing the bookings, and the clinics." ..If its boring or nothing happen we go back on the wards now which is better".*	**Paediatrics**
Community & out with Social worker	**Family centre** *"they weren't expecting us...a wasted day"* (1day)
Hospital	**Paediatrics** *"nobody to talk to everyone busy running around, I stood in the middle not knowing what to do"*
Health visitor, social worker and community	**Antenatal clinic**
Postnatal ward *"most of the time.....it depends who you work with"*	**Paediatrics**
Community *"one to one basis with the same midwife , gain confidence ....[but} only two days a week, actually saw no deliveries the whole time.*	**Postnatal** *I was glad it was only two days a week, I absolutely hated it..no mentoring, I felt generally just useless."*
Delivery *"the births were alright"*	**Delivery** *"my mentor was so stressed out"*

Antenatal[3] *"I enjoyed it but...some days a waste of time, nothing organised, didn't like the numbers in parentcraft group felt there were too big-I'm not looking forward to doing that"*	**Postnatal**[4] *"thoroughly enjoyed on the second allocation had a good mentor, who taught me a lot"*
	Delivery *"mentorship has gone completely to pot"*
Community *" I love the community I would much rather be there than in the hospital"*	
Antenatal *"I really enjoyed , I was really nervous at first because it was the first hospital allocation but it was really good"*	
Delivery *"I was really looking forward to, it was exciting at first but I had a really long allocation there .....I had been up there for fourteen weeks and in the end I was really stressed so it was a bit of both,it was having to learn all the new things and my mentor was good but a perfectionist and when you are trying to learn new things and get to know the women.and do everything perfectly it became so stressful"*	
Postnatal *" its mainly good but as ( ) says it depends who's on duty... but generally positive"*	

4.0 What is the role of the midwife?

In pairs the group thought about how they would define the role of the midwife These were the definitions we came up with:

1. *A named advocate for women giving continuity of care. She's knowledgeable, sympathetic, with time to listen. Competent decisive and independent. (ideally)*

2. *Carer, educator, counsellor, communicative, skilled, responsible and competent in all areas (pre-conception all the way through).*

3. *Practitioners, competent in all skills and aspects of care. Carers showing empathy, health educators, act professionally and good communicators. Responsible for own actions.*

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[3] & 3 This person clearly had mixed feelings about antenatal and postnatal experiences both had aspects which were enjoyable and others which were less enjoyable and they could therefore be easily located in the two categories.

4. As above, plus must keep themselves up to date with recent research.

There was general agreement about the role of the midwife. We then looked at the definition of a midwife contained in A Midwife's Code of Practice (p2) and compared this with those of the group.

We considered whether the role of the midwife might be affected by the development of pre-registration midwifery. It was suggested that midwifery is becoming more research-based. Although we then debated to what extent changes could be attributed to pre-registration courses since concurrent changes in the post-registration courses are taking place. In particular the introduction of more psychology and sociology into the curriculum was cited and it was suggested that less anatomy and physiology is being taught, but another student said*"whether or not it will make us better midwives I don't know"*. JK asked what the group thought about the view that pre-registration midwives are more health focussed because they are not nurses. This idea was accepted and one student explained that when a woman is ill and needs to be "specialed" they get a nurse to look after her rather than a midwife (with no nursing experience) *"and I don't think they will ever think that we are competent to actually nurse them"*. For the group it had not been an issue that they are not nurses but at the same time it was felt that it would take some time for others to "get used to pre-registration midwives ". In general nursing areas where the students go it was thought that due to their lack of experience in nursing they are expected not to be able to do even basic nursing tasks (eg. take a blood pressure).

5.0 What kind of skills do midwives have?

Since it is sometimes said that pre-registration midwifery students do not have nursing skills we tried to list the skills midwives have. This was another way of thinking about whether midwives need nursing skills.

Knowledge of pregnancy - need to know the normal so that you can spot the abnormal. Unlike doctors who see pregnancy as normal only in retrospect midwives see pregnancy as normal.

Basic caring skills:
- *Basic Observations*
- *Blood taking*
- *Palpations (nurses don't do this)*
- *Injections*
- *Infusions*
- *Communication skills*

Booking-taking a history (we do it better than nurses)
Using equipment
Delivering a baby
Vaginal examinations
Caring for a baby (bathing etc)
Helping with breastfeeding
Advising
Educating (hygiene)
Removing clips/sutures/stitches
Aseptic technique (nurses don't think we can do this)

The most helpful thing in learning these skills was seen to be practice, midwives having confidence in the students' ability to do it. Obstacles to learning were cited as midwives teaching and conflicting advice from midwives.

6.0 Traditional midwifery skills

JK read an extract from the article from Kargar 1990 for comment and discussion (see attached) and we asked "How far does technology shape the placement experiences".

The group recounted how monitoring equipment is used more often than a Pinard stethoscope and students have had little opportunity to practice this skill and it was felt that intervention in labour was frequent. At the same time often in the community there was a case made for using a sonic aid *"so that the mother can hear the heartbeat"*. In B the same equipment is available and used but the students are taught to use a Pinard before using the monitor. It was felt that in the midwifery-led unit there was less use of technology *"because we haven't got the doctors"*there Whereas other midwives acted as *"maternity nurses"* working with doctors in B this was less so. The group said that they are only "just" learning traditional midwifery skills and one person described attitudes to different positions for delivery and an example when one midwife considered it *"too animalistic"* to deliver a woman on all fours. JK asked how aware are the group of conflicting views of the role of the midwife and are there a lot of contradictions?. It was thought that the students needed to be able to distinguish for themselves what is good or bad practice. Some in the group described a more consistent approach to care in their unit (B) and therefore they were less conscious of differences while others (at P) were distressed by the kind of care they saw and were reluctant to discuss it. They did say that a lot of medical intervention was evident in P (caring for the high risk women) and there is high involvement of registrars and consultants.

7.0 Conclusions

The group seemed very relaxed in this session and enthusiastic about recounting their experiences. It was more difficult to develop a critical analysis of these accounts and there seemed to be some hesitancy about listing the skills the of the midwife. The session did enable us to examine student's experience of clinical practice and supplemented the earlier session which looked at the education institution as a setting for student learning. We had tried to look at competing views (ideologies) of midwifery- the role of the midwife and midwifery practice and the contradictions group members faced daily. Some of the group are quite dissatisfied with their placements, others less so. In conclusion each student was invited to say one thing they would like to change about the placements and we listed these:

Students placed at P said-
See more normal deliveries
More set time in one place
Go to B to see low risk unit, and use a Pinard

Students at B said-
General placements earlier in the course "to give you more basic nursing skills"
Come to P to see "high risk/abnormals" earlier "to give you a little bit of idea so that when in groups discussing care..."

Students at W. Dorset said-
Staff to have more confidence in their own practice for our learning and us
More clinical input earlier(days on the wards), less theory, to achieve continuity
Spend time in B low tech unit.

8.0 **Writing a report on Group Inquiry**

JK outlined the current fieldwork phase of the evaluation project and the need to produce a report on Group Inquiry. As a way of structuring a discussion about how to write this report and what to include, each group member was asked to jot down some notes, taken from earlier feedback and group inquiry documents and to bring these to the next meeting on Thursday 20th May 1993 at 10.00am. A further meeting in July/August to agree the report will also be arranged. It is expected that the group's report will be included in the final evaluation report (which may later be published by the Department of Health). The group's report may then be seen as set in the context of the case analysis which will also be contained in the evaluation report and which will be presented to an invited audience at a case site meeting in the summer of 1993.

JK/4/93

APPENDIX 16 GROUP INQUIRY 2

An agreed account of the students' experience of inquiry together (Process).
(reproduced in Kent et al 1994)

Workshop 1
JK wrote to us inviting us to take part in a research project and asking for the chance to discuss it with us. (GI)(03)(01).

A slot was timetabled for us to meet with her and hear about the evaluation and the involvement we could have. JK outlined the purpose of the evaluation and the idea of group inquiry. Although our tutor had said that we had to take part in the research, JK explained that it was entirely voluntary.

We asked a lot of questions about the research- how would it be used, would we be able to see the report before it was sent to the DoH? How far did MRA already have formed views about pre-registration midwifery and what were these? We wanted to know how much time would it take and would JK agree to stick to the time set aside for the work?. Would people be able to express their views in a group or would fewer opinions be expressed? If not everyone wanted to take part would that matter and could people leave the group and others join? We also discussed the confidential status of what would be produced by the group and we wanted to know what JK's PhD would be about since this inquiry was to be part of that work. We didn't want to be negative about pre-registration midwifery and spoil it for others and so we wanted to look at both positive and negative aspects.

JK explained that we would not be able to see the evaluation report before it went to the DoH but we could discuss the possibility of sharing with her what she would write about the group inquiry since this was consistent with the collaborative approach of the method. Access to meeting notes and tape recordings would be limited to the group and the MRA research team. Since taking part in the inquiry was voluntary, people could leave but it would not be possible for new ones to join since the group discussions would need to have some continuity. JK briefly outlined the focus of her PhD and promised to stick to the allotted time. We were asked to expect meetings to last one-two hours and be held every three or four months. She left the room while we discussed whether or not to take part.

All twelve of the group agreed to be involved and at the end of the meeting JK gave us a letter which explained in writing the aims and purpose of the inquiry. Looking back, it was good that we asked so many questions and were cautious about the inquiry. Some of us were unsure what it meant to have an 'official' mouthpiece for grievances about the course and who might hear about it. Even so we did not realise just how much would be involved and were unclear about the aims and purpose of the inquiry, neither did we realise how much time and commitment could be needed to do justice to the research

For the remainder of this first workshop we spent time thinking and talking about why we had become student midwives, what we thought being a midwife meant and the good and bad experiences we had had on the course so far. We did this by brainstorming ideas, talking in small groups and taking turns to recount our experiences. By asking these questions we were becoming aware of the issues and we had the opportunity to hear each other. We needed to be able to disagree with each other and feel supported It made what we were doing on the course more tangible.

Workshop 2

We examined the feedback from workshop 1 and tried to identify themes from the earlier discussion. Many of us had not systematically looked for themes but we had read over the feedback and given the matter some thought. In some ways it was tedious looking back to the last workshop three months ago because we had moved on from there. However this workshop did indicate both the extent of agreement in the group and diversity, as each of us completed an evaluation form when we individually rated the themes identified The workshop confirmed individual and other's perceptions and feelings while also providing a framework to assess on-going experience and some things to look out for.

We had been asked to write about "significant events" that had occurred within the first three months of the course. Few of us had prepared these prior to the workshop so we discussed experiences in small groups rather than read accounts we had written. Then one person from each group reported their experience We tried to identify the themes and issues from what was discussed. JK asked us to write down our accounts after the workshop and six of the group sent these to her. She sent us a short paper on the group inquiry method from Working Paper 1 (Kent & Maggs 1992).together with copies of the accounts we had written and a summary of the evaluation sheets in preparation for workshop 3.

Workshop 3

Nine of us attended this workshop (one of the group had by this time left the course). We recounted aspects of our experiences over the past three months and tried to identify what the issues were, whether they were the same as those raised by the written accounts. We considered what changes we would like to make and discussed the obstacles to change. We also reflected on our previous experiences of groups and the consequences of being in a group. This was a way of highlighting aspects of the group inquiry method.

We recognised that being in a group could mean that an individual does not feel alone but at the same time they could feel like outsiders or indeed everyone in a group could feel like that. We acknowledged that individuals might feel their ideas are compromised or moulded to the majority and that it was sometimes difficult to speak in a group. Groups can become one-track and one topic or one person may dominate the discussion. More positive aspects are that groups can be supportive and confirm feelings individuals might have. they can also provide a safe and comfortable

environment in which opinions and feelings can be expressed. They can be extremely important and one of us said it was the only thing that kept her going on the course (not the group inquiry but being part of a student group). Groups also can provide the basis of long lasting relationships.

Workshop 4

Although there was the opportunity to comment on the feedback we seldom did. There was not always time to spend reading over the papers JK sent us. We also felt that since we had other opportunities to share our experiences within the group we didn't need group inquiry to enable us to do this. Our anger and frustration about our experiences of the course and midwifery care spilled over into the inquiry and in this workshop we were generally irritable, resentful and hostile as a consequence. The inquiry gave additional focus to the issues being raised and provided a forum for expressing our anger and frustration. In some cases it increased our understanding of what was going on and listening to others in the group provided alternative interpretations for understanding what was happening. We told JK that we had taken part in the research because she asked us to. The inquiry was seen to only have value in so far as it was instrumental in bringing about change. JK suggested that this meant we needed to demonstrate the relevance of our experience for others, to go beyond our subjective views and develop an analysis and critique of them.

We would have liked JK to put us in touch with other student groups but she explained that her role was not as a messenger between groups but we could be involved in communicating the group work to others in the future.

At the previous workshop we had agreed to write an account of a good and a bad experience for this workshop and six of us had done this. Since we had already discussed these with each other writing about them seemed less useful and the accounts were much shorter than earlier ones we wrote. Analysing the accounts proved difficult - we could not easily identify themes or issues arising.

We discussed "philosophy of care" and how "normal midwifery" could be defined and read two articles one by Downe (1991) another by Flint (1985). The second of these was a prompt for us to examine what we thought midwives needed to learn.

Agreement in the group was less widespread than perhaps had been the case earlier on or perhaps individuals felt more able to express diverse opinions?

Workshop 5

The department had moved so workshop 5 took place in different surroundings. One of the group had joined a later cohort to retake the year after failing the first year exams so there were then ten students in our year We were all feeling rather despondent at this time and defeated, wondering whether our efforts to become midwives were after all worthwhile. As with course itself, this workshop was hard going, we felt very low,worn down and aware that we might be letting JK down by our half-hearted participation

in the inquiry. At times some of us were not clear what we were being asked to do. Nevertheless the group discussions did give some relief to frustration and a chance to reflect on and peruse past events and how they related to us individually and as a group.

Since earlier sessions had highlighted that midwives may not always be able to give care in the most appropriate way we had chosen to look more closely at "the context of care", to consider how and in what ways this shapes the kind of midwifery care women receive, the midwives' role and our experiences of being students on this course.

We "brainstormed" what could be meant by the context of care and discussed constraints on the delivery of midwifery care which have in turn shaped our learning experience. We then examined the shape of the educational establishment and the organisation of midwifery services represented them diagrammatically and identified the personnel involved in each case.

We theorised what could be meant by a "medical model of midwifery" This was quite difficult to do since we were now familiar with this dominant approach to care so it was harder to stand back and identify features of it.

We agreed that workshop 6 would provide a chance to discuss the non-midwifery placements in some detail.

Workshop 6

As with other occasions it was not always easy to find the time to read the papers and feedback from the previous workshop. For some of us the feedback did not always record in sufficient detail individual views and the group process meant that some members felt that it was difficult to disagree with the majority view which was in turn frustrating. This was seen to be a weakness in the group inquiry method where peer pressure could prevent individual members expressing their views. It was felt that the opportunity for individuals to respond in confidence is less biased and a case for individual questionnaires was made. It was suggested that the inquiry lacked clarity, direction and substance that there was no clear agenda and no real incentive for students to take part. What after all could be the benefits to us? If there had been no other outlets to share within the student group how we felt about being on the course taking part in group inquiry would have been a wonderful opportunity. Nevertheless it had been interesting.

JK had also sent us a copy of Kargar 1990 and we began this session by asking are we learning traditional midwifery skills?

We went on to draw a diagram or map of the course and where we had got to. This was fun and we laughed a lot at each others efforts! We then wrote accounts of our experiences of non-midwifery placements and read them to each other. This gave each person a chance to say something and express a view. By discussing them we tried to identify the key issues that had come up which led into an exploration of the differences and similarities between nurses and midwives. JK read to us a short article by Downe (1990) and asked us

whether pre-registration midwifery is a way of achieving separate status for midwives. She also suggested that a paper by Ho (1992) contributed to this debate.

In conclusion we discussed briefly an outline of how we could write about group inquiry for this report and agreed to look back over the workshop material and try to jot down some notes so that at the final workshop we could agree what might be included in the report (JK provided a full set of documents). JK proposed that an account of a student's experience written in the voice of a student would be a way of representing the views of the group and encompass aspects of our experiences and theorising about those experiences.

Workshop 7

We arrived at this final workshop unprepared. None of us had spent much time writing notes and we felt embarrassed not to have done this. This led to a discussion about how much we had contributed to the inquiry and how often we were unable to do as much as we would have liked. Some of us felt that we were still unclear about the aims of the inquiry and had not realised at the beginning that we might need to refer back to the notes we had received. So this workshop provided a chance to try to make sense of what had been achieved. We were being asked to do three things:

1. Reflect on being a pre-registration midwifery student.

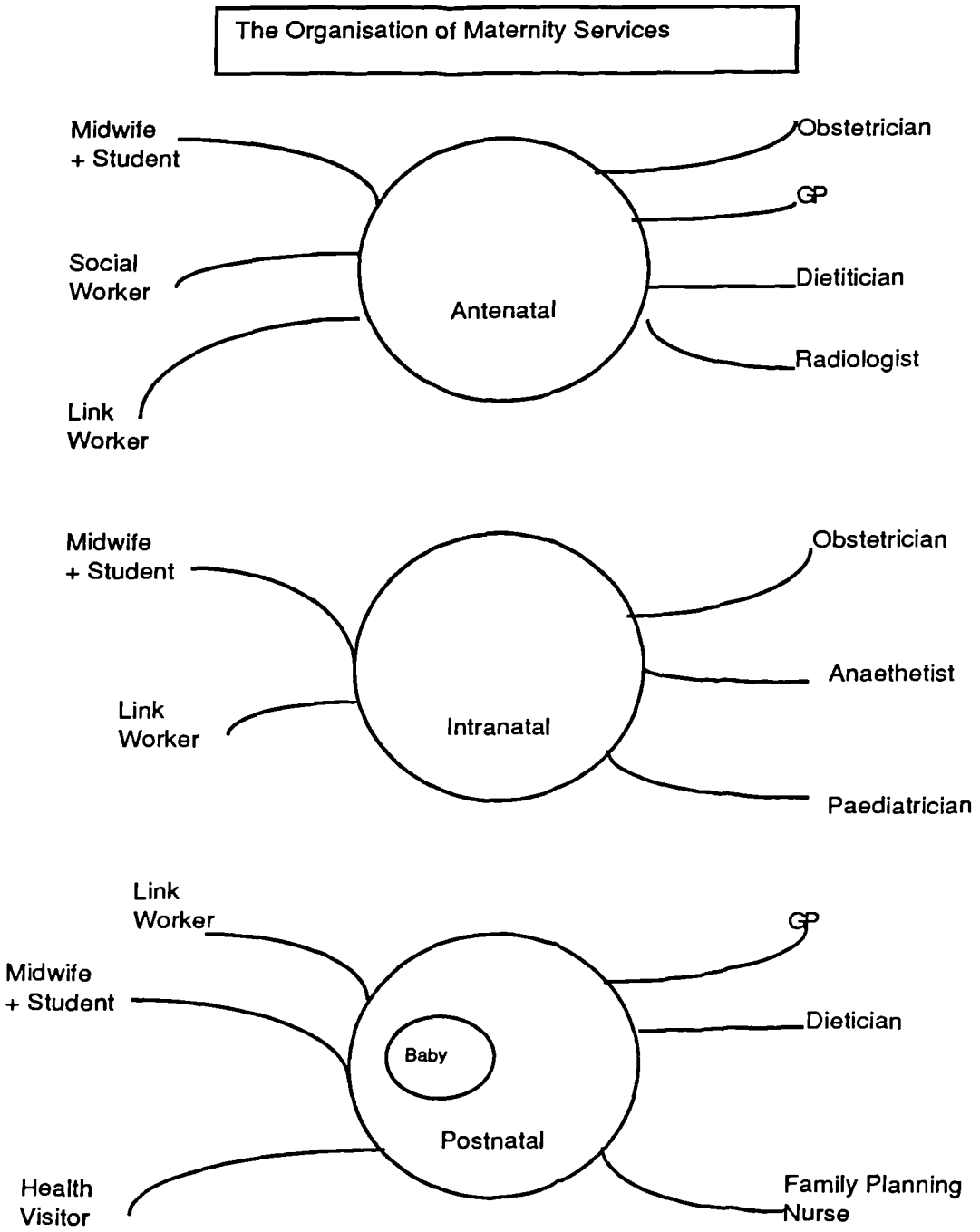
2. Reflect on the group inquiry process

3. Assist in constructing a public account of group inquiry and our views of being a student on this course.

Together with JK we went through the material for each workshop and reflected on what had been said and how the inquiry had gone. It was agreed that JK would draft the report and send each of us a copy to comment on. This was consistent with the intention to share with us each stage of the research process as far as possible and to enable us to contribute to the final evaluation for the Department of Health. At this stage we were unsure whether to reveal our identity and 'own' what was written so each of us was asked to indicate in our response to the draft whether or not we wished to be identified. Only if everyone in the group was willing to do so would this go ahead.

We hope that our voices as students will be heard. We have spoken here with one voice to represent the extent of agreement within the group about the issues identified and highlight the shared experience of being on the course and becoming midwives. This consensus is a product both of our social position as student midwives and of the inquiry process.

APPENDIX 17
Picturegram of midwifery services by (Group 2)



APPENDIX 18 GROUP INQUIRY 2

Workshop plans 1-6

Introductory workshop - as in appendix 10

Workshop 2 - as in appendix 10

Workshop 3 - as in appendix 10

WORKSHOP FOUR- PLAN

1. Go round the room and each person say one thing they would like to get out of today's session. (This is to share the agenda setting process)

   Record on flip chart - aims for today.

2. In small groups allow each person an opportunity to describe their positive and negative experience.

   In the groups try to list the issues, themes that run through the accounts.

3. Feed back the list to the large group.

4. What is normal midwifery? BRAINSTORM

   Discuss - Why is defining the normal important? How is it defined?

5. In small groups - As students of midwifery what do you need to learn? list on flip chart the skills, subject areas/ topics you consider necessary. If you have time try prioritising them?

8. Did we meet the aims of individuals in the group for today? (return to initial agenda).

9. Plan for next workshop.

WORKSHOP 5 - Plan

At the last workshop we discussed "normal midwifery" and what it might mean. Comments were made which suggested that the opportunities to practice "normal midwifery" were limited by "the context of care". So we have decided to explore in more detail what may be understood as the context of care which has an influence on both the kind of care women receive and the experience of being a student on the course.

What features of the CONTEXT OF CARE can we identify? BRAINSTORM

Divide into two groups - pick one of these and discuss in what ways it is important
a) for you as students.

b) for women receiving midwifery services

List your conclusions.

Group A
List those people involved in providing midwifery services

Try to draw a diagram of the structure/organisation of the service.

Group B
List those people involved in providing the pre-registration midwifery course

Try to draw a diagram of the structure of the institutions providing the midwifery course.

What are the consequences of the structures?

What changes, if any, would you like to see in

a) the course.

b) the organisation of the service

One of the concerns expressed at the last workshop was that there is too much "medical intervention" into midwifery care. What form does this take? What is the medical model of midwifery?

Is this dominant and if so why?
As midwife students how has this affected you?

WORKSHOP 6 - Plan

Any comments on WORKSHOP 5 feedback?

Are you learning traditional midwifery skills?
Traditional Midwifery (*Refer back to the article by Flint:Skills behind the scenes)*

The primary focus of this workshop is to discuss the general, nursing placements. This is so that you can critically assess their value and to provide a means for examining the competing ideologies of nursing & midwifery. We can consider how power structures the relationship between nurses/doctors and nurses/midwives, nurses/patients and how the language of nursing and midwifery differs or is the same.

Where have you got to on the course?
Each person draw a map/pathway of where you are on the course showing the placements you have done and marking time on your diagram/picture. *(While placements are part of a shared experience they are also individual)*

FEEDBACK - talk about what you have done.

What significant events have occurred on general placement?
Each person write about a recent event while working in a general area. (to hand in at the end).

Each person read out their account.

Discuss:
- why was it significant?
- was it postive/negative?
- what did you learn?
- contrast and compare accounts - how are they same/different?

Is the purpose of these placements to acquire nursing skills? If yes what is meant by "nursing skills?*(or what were the objectives for these placements?)*

BRAINSTORM

See also articles by Ho (1992)Midwifery and nursing: in search of commonalities, Flint (1986) Should midwives train as florists?

In what ways do nurses and midwives differ?
In what ways do nurses and midwives are they the same?

FEEDBACK on flipchart (take turns for each person to speak)

See article by Downe 1990 Midwives stand alone

So is pre-registration midwifery an important way of achieving separate status for midwives?

How different are pre-registration midwives from post-registration midwives? (*Ideologies of midwifery- how the role of midwives are defined and understood)*

Will pre-registration midwifery courses make a difference
a) to services for women? *(NHS based on illness model)*

b) to careers for midwives? *(the role of the midwife)*

c) to the status of the midwifery profession? *(separate from nursing academic credibility)*

Writing a group inquiry report

APPENDIX 19

Extracts from replies to letter sent out when students in each group had completed their course and qualified as midwives

STUDENT 1 (from Group 1)

This student was working full time in the hospital where she trained.

"I still maintain that University Education/the amalgamation was not a good idea. I do believe in higher education and I realise that to obtain a diploma - an institute of higher education is required. However I feel that midwifery would not be becoming quite so 'lost' in the world of higher education, if it had remained with schools /colleges of midwifery, with day release type programmes to univerisities, to gain the necessary diploma/degree. I also feel there should be more emphasis on the practical side of the training. I feel the training is becoming too theoretically lead, with little thought from the universities on the practical side."

Having read about Group 2 this student also commented *" I do feel that a lot of what came out Group 2' inquiry is/was similar to that of our inquiry group, except we did not discuss these matters as, at the time we felt more strongly about what was happening to our education. I do feel that the two groups actually discussed very different areas of midwifery and therefore should not be compared."*

STUDENT 2 (from Group 1)

Student 2 was not working but had managed to get a part-time job on a fixed term contract, thirty miles away which was due to start soon. We spoke on the telephone and she told me that although there had been five vacancies since she and the others qualified only one of them, the youngest student had been employed on a grade D. Since qualifying in August they had been offered part-time occasional work on the bank again on a grade D. They had sought assistance from the RCM who had taken up their case with the trust. However the trust had responded by saying that if there was nothing in writing to say that midwives must be paid on a grade E then they would continue paying grade D for those qualifying via the pre-registration route. The explanation for this is that as direct entrants, with no managerial experience,.these midwives need supervising and experience before being able to take on the full responsibilities of a grade E. They had been told that they would individually have to be assessed before being able to recieve grade E even though they have been registered as qualified midwife practitioners. She felt that they had been badly let down, that the hospital had treated them particularly badly because they are 'direct entry' and because they are mature women. She described how the younger students had been able to get jobs much more easily. Some have moved away. According to her the school were "just not interested".

Two other midwives have decided to work in SCBU, partly due to financial difficulties. Now she felt very disappointed and as though after three years hard work she had a qualification which wasn't worth the paper it was written on. She felt that these negative attitudes to pre-reg were specific to this hospital and when she had the chance to work at a different one she had been treated quite differently and given the responsibilities of a senior student. I asked how, given the lack of support and difficulties she described as continuing since we last met , had she managed to keep going and finish the course? She said she had made up her mind to do midwifery and had studied for GCSE's to get on the course, she was determined to do it and no-one was going to put her off. She was absolutely committed to becoming a midwife and as an older entrant she planned to devote the rest of her working life to it while younger women might take career breaks later on. She hoped that in time things would change, that people would realise that pre-reg midwives were okay. As more qualified she thought this would happen. She felt that the study should have continued to see the students through to the end of the course and what happened next. Looking back on group inquiry she felt it had been enjoyable and worthwhile. She

and some of the others had thought about writing a letter themselves saying what it was like now they had qualified and I encouraged her to do so. She commented on how different the other group I wrote about were.

STUDENT 3 (Group 2)

This student was due to start a job-share and noted that ironically, it was her lack of 'nursing skills' that was a worry.

" In retrospect I would not have changed anything that was said at the group discussions and, even at the (course) *evaluation, the same old problems of linking with midwives, not enough time in the clinical area and too much time out of midwifery, were thrown up. The course is still relatively new. Changes are being made all the time as a result of our evaluations and life is perhaps a little easier for subsequent groups on the course if only because the midwives understand the course a little more. ....I still think there needs to be more emphasis on clinical time in the course, working with experienced and like minded midwives - not on the general side on surgical and medical wards!"*Also *"I believe the course and the hospital is more forward thinking than I realised at the time. Particularly good was the neonatal input which will enable us to be more autonomous once the teams in the hospital are up and running".*

About the inquiry itself she said *"I really am not sure of the value of the inquiry. We would have met as a group anyway (I think that is why we appeared tired and apathetic at times with you as we had already flogged the issues to death ourselves and at the evaluations). If it gets pre-registration midwifery more recognition then it would have been worth it. Also if it gets you your PhD all the better".*

Student 4 (Group 2)

This student did not say whether she was working. She did give her views of the course now:
"I feel quite positive about it because I have gained a lot from it in terms of knowledge I have acquired, interesting life experiences, professional qualification and personal credibility, friendships, some confidence about women's health and the process from conception to birth and beyond etc. I think the tutors did their best and the midwives accepted us. Because I think there is an insecurity in the profession about justifying itself there is an excessive tendency in the course to do so academically by accumulating scientific knowledge at the expense of practical experience and human contact and communication. So in a way it is good the course did not train us to think one way but made me more critical about the care that we give and the stuff that we were taught."

In relation to the inquiry process she wrote *" I must admit it meant very little to me and I see it as your job, your interest, your remand. I did not mind taking part in it. Any one person's views are extremely diluted for us to feel any ownership. It was interesting to read some of the results you have produced and I hope they are taken into consideration in the future programming of midwifery training".*

She recommended the following changes to pre-registration midwifery education:

- *less nursing placements*
- *more apprenticeship type learning with a qualified midwife we resepect*
- *greater continuity of care for the same clients so we learn what happens next to the women and babies we meet.*
- *the introduction of an analogy between being born and dying so we understand both processes and become more relaxed about them. I believe a placement in a hospice is appropriate.*
- *less concern about universities and degrees*
- *not to increase the length of the course to 4years in order to make it more academic. The practical skills and confidence we acquired were barely sufficient to prepare us to practise autonomously. Only increase the length of the course in order for the latter aspect to be expanded.*
- *greater emphasis and clearer instructions on how to deal with emergencies.*

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29 April 1994

Dear Julie

RE: CONSTRUCTING ACCOUNTS OF BECOMING A MIDWIFE

I hope you received my telephone message giving clearance for this paper on Tuesday, bearing in mind the very short timescale given.

I thought it would be useful to follow it up with a letter, since although we have cleared the paper, both the customer and I felt that there were methodological shortcomings which you would want to think about (and which hopefully your audience will want to debate). I can only list some of these rather briefly here.

I do have some sympathy for feminist research, although I don't find it particularly useful when it sets up a straw man, 'malestream research'. Do you then privilege the accounts of those who you perceive as underdogs, and assume that their version of events is the 'correct' one?

Secondly, there seems to be risk of divorcing the students' accounts from the situation in which they were produced, and thereby implying that they are generalisable, particularly since you give no information on the numbers involved. The technique of using a fictionalised student also gives no room for indicating the range of opinion.

Thirdly, you claim to draw attention to the circumstances of knowledge production, but the lack of context in the paper does not enable that to happen. For example, to what extent are the students' opinions shaped by those of their lecturers?

These are only brief comments since it is not my role to give a detailed critique of your paper, but I hope that you have an illuminating time delivering it.

Best wishes.

Yours sincerely

RESEARCH & DEVELOPMENT DIVISION

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